VOL. 12, NO. 1 MAY-JUNE, 1962

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

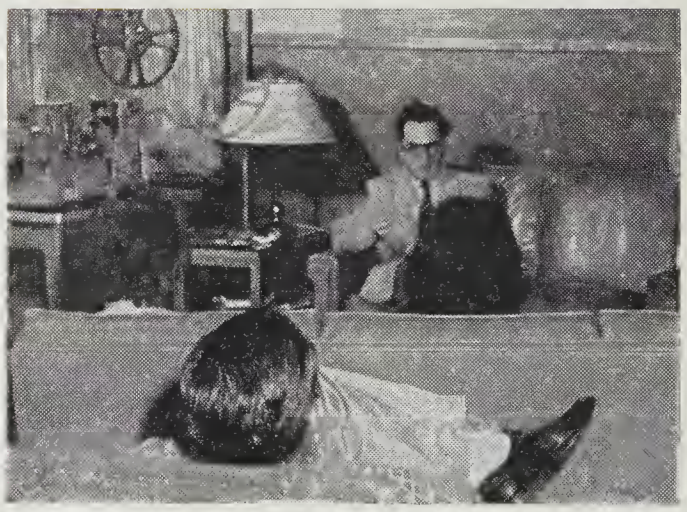
EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.



Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Medical Director, one other physician, a clinical psychologist, a psychiatric social worker, a chaplain and admitting officer, a vocational rehablilitation counselor, a recreation director-occupational therapist, and a full attendant staff.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment in response to written or telephone request to the Medical Director of the Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment. All appointments must be confirmed by mail.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Services Agency, and a complete medical history, compiled by the patient's family physician, are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M., to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
Patients must be sober upon admission, and in good physical condition. Patients may have visitors after they've been at the Center for 2 weeks. Visiting hours are from 1:00 - 4:00 P.M. on Saturday and Sunday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

NORBERT L. KELLY, Ph.D.
Associate Director

DONALD MACDONALD, M.D.
Medical Director

GEORGE H. ADAMS
Educational Director

INVENTORY

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RALEIGH, N. C.

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THE AWFUL WORLD of BLACKOUT

BY HERMAN E. KRIMMEL
DIRECTOR OF CASEWORK SERVICES
CLEVELAND CENTER ON ALCOHOLISM

• *The blackout can be the crisis that impels an alcoholic to seek help.*

RECENTLY one of our patients commented ruefully, "My friends keep telling me that I'm the life of the party but I always have to ask them what they are talking about." He is a man who is unable to remember his behavior at these parties nor can he remember how he got home. Sometimes he cannot even remember that he has been at a party.

Like many alcoholics, he is the frequent victim of a frightening phenomenon called a blackout. Contrary to widespread misunderstanding, a blackout is not the same as "passing out" during a too convivial evening. The experience of passing out is common to many social drinkers. One imbibes too freely and falls asleep on the living room sofa. If the host is benevolent, the offender may be left there to sleep it off. The more fastidious host may remove the prostrate form to another room so that its presence does not aggrieve the sensibilities of other guests. After the inebriate revives, his wife (thoroughly outraged by this time) will drive him home to the accompaniment of a severe tongue lashing. But except for that assault on the eardrums and the possible distress of a hangover, little damage will be done.

These lines are not written as an endorsement of passing out at social functions but to emphasize the difference between that and a blackout which can be dangerous as well as terrifying. During a blackout there is no loss of consciousness but the victim can recall little or nothing of what has happened. He may, for example, drive to a distant city and register in a hotel. His behavior is seldom bizarre and those who see him may think he is a bit tipsy but nothing more. But when he wakes up the following morning, he has no recollection of the journey or of the process of registration. The most frantic searching of memory is futile. No effort of concentration can conjure up the events that occurred during a blackout.

The average blackout results in the victim's inability to remember the crazy things he said or how he got home the night before. But it can be more dramatic. Alcoholics who beat their wives have said that they could not remember striking a single blow. When told of their behavior

Reprinted from THE NEWS, published by the Cleveland Center on Alcoholism

they were appalled and felt guilty.

One man said that he woke up to find his feet badly cut and caked with dried blood. He could not recall anything that had happened and was incredulous when his wife acidly informed him that he had celebrated the previous midnight by imitating a primitive dance on broken glass.

Another patient completely demolished the lower floor of his home while his panic-stricken wife and children watched. He smashed the furniture, ripped the draperies and gouged the walls. When he saw what he had done the following day he was aghast but could not remember any moment of this carnival of destruction.

Some alcoholics have said that the inability to recall what one has done is harrowing but even worse is the possibility that he cannot effectively deny accusations of involvement in an accident or even a criminal act because he really doesn't know. This may be a rare experience, but it does happen.

It happened to a friend of this writer. He is a man whose achievements and contributions to his community in the past ten years have been outstanding. In his earlier days, however, his life was violent and included four penitentiary sentences as well as years of severe alcoholism. During one of his lawless escapades, he held up a pair of motorists and forced them to leave the car. He drove the stolen car across a state line which, of course, made the act a federal offense.

Coincidentally, a double murder was committed in the area and the owners of the car told police that their assailant was also the killer. When arrested, our friend could not recall the events because he had been drunk and blacked out. The only thing he was sure of was his belief that he had not killed anyone. Nevertheless, he could not account for his activities and his denials were unconvincing. Today, he still shudders when he thinks that he might have paid the penalty for those murders had it not been for the conscientious work of Federal investigators.

That may be an extreme illustration, but it does show what can happen.

The literature of alcoholism contains little about the dynamics of blackout. A few authorities have speculated about their cause and meaning. Some say that a blackout is, in essence, a complete rejection of reality by the individual and temporary but total flight from the present. Others have said that it is not really forgetting. Instead, it may be a period during which alcohol has affected the higher cognitive functions of the brain so that events during the period of blackout did not register.

No explanation has been highly satisfactory. The important point, as emphasized by Dr. Giorgio Lolli in his book, *Social Drinking,* is that the "onset of blackouts is an ominous sign, a dangerous evidence of incompatibility between the individual and his drinking habits."

If there is a positive result from a blackout, it is that many persons are rudely jolted to an awareness of their alcoholism by the experience. It can be the crisis that impels them to seek help.

Some ignore the significance of these experiences, especially if they are not dramatic, and wait for other and more grim disasters. But surely the blackout is one sign that can be explored by those working with alcoholics. Many patients who dismiss the other warnings are impressed by this one.

Heard Radio Announcements

I have heard your announcements over the radio and would like very much to have any information on alcoholism you can give me. I have a son in need of help very much. I would like to hear from you as soon as possible.

Anonymous
Kinston, N. C.

Excellent Articles

I want to take this opportunity to thank you for having sent me your *Inventory* journal during the past year. The articles in your magazine have been excellent and have been very helpful in my work with alcoholics. I am active in AA and there is so much of your material I can use in AA work.

Anonymous
Wilmington, Delaware

Help in Minister's Work

I am a Baptist Minister in Columbus County. I ran across copies of *Inventory* while serving in our Volunteer Chaplain Program at the County hospital.

I believe *Inventory* would be a great help to me in my work and would appreciate being put on your mailing list.

Rev. Wiley I. Rutledge
Whiteville, N. C.

Request From Student Nurse

I am presently a sophomore student in the Duke University School of Nursing. I am a member of a group that is working on a project on alcoholism. We are primarily concerned with the nutritional aspects of the sickness—how it affects the body and what rehabilitative measures can be taken to cure or compensate for the effects of alcohol on the body.

We would appreciate any information you could send or any resources to which you could refer us.

Janet Stevens
Durham, N. C.

Seminary Student Writes

For a course at Southeastern Seminary I am setting up a file that will be helpful when I serve as a pastor. I would appreciate any free literature or book listings dealing with alcohol and the family that you could send me so that I might be better able to deal with this problem.

Troy Petty
Wake Forest, N. C.

Copies For Clergymen

Our group is conducting a campaign to promote a better understanding of the alcoholic and alcoholism among the clergy of our area. We were so impressed with Dr. Clinebell's article, "The Church and the Challenge of Alcoholism," in the November-December issue of *Inventory*. Since it isn't possible to obtain copies of *Inventory* for each clergyman we wish to contact, may we make mimeographed copies of this outstanding article to pass along to members of the clergy?

Inventory is priceless. Our AA and Al-Anon groups find every issue full of good material that helps keep us up to date on the alcoholism problem.

Anonymous
Beresford, South Dakota

VOL. 12 NO.1 INVENTORY MAY-JUNE, 1962

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

TUBERCULOSIS and ALCOHOLISM

BY HENRY T. TESCH

FIELD REPRESENTATIVE
ALCOHOLISM CONTROL PROGRAM
NEW JERSEY STATE DEPARTMENT OF HEALTH

The successful control of tuberculosis may depend upon chest disease hospitals exerting greater efforts to treat concurrently the disease entities of tuberculosis and alcoholism.

Reprinted by permission from PUBLIC HEALTH NEWS, published by the New Jersey State Department of Health.

AT the outset, it should be made clear that we do not profess to have answers for all the problems which beset the tuberculosis patient with chronic alcoholism. Surveys indicate the incidence of tuberculosis among alcoholics is much higher than among the public in general. At the present time, even with our ever increasing scientific knowledge, we cannot account for this occurrence with certainty. Yet, because of its prevalence and seriousness, it is commanding more and more the attention of the staffs of chest disease hospitals.

The Alcoholism Control Program of the State Department of Health in November, 1952 established a pilot study in the Roosevelt Hospital for Chest Diseases in Middlesex County to see what might be done to assist the rehabilitation of the tuberculous alcoholic patient. As a demonstration, it was the first established in a New Jersey chest disease hospital. The program was simple. It was based upon the premise that if the tuberculous patient who is also an alcoholic accepts his alcoholism as a treatable disease, recovery is possible.

From experience we know that chronic alcoholism, as manifested by the victims' compulsive drinking and loss of control, cannot be "cured" medically, but in total abstention it can be arrested. To that end, our efforts were directed toward educating the tuberculous alcoholic of his need to learn how to live a constructive and meaningful life without alcohol. This is not to say the alcoholic may not have need for medical treatment or in-patient care. Hospitalization may be indicated in the acute phase, in the hangover state, after periods of prolonged drinking, or for malnutrition, deficiency diseases, or other illnesses which may be directly or indirectly attributed to alcohol. Often these people need to be hospitalized not because of their drinking, particularly, but for the untoward effects drinking may have created.

He may get over his acute intoxication with or without medical treatment. He may even recover from

his chronic condition, but the alcoholic can never be cured in the sense he will again be able, with any degree of consistency, to control his intake of alcohol. There is always the risk and danger of relapse to former drinking behavior.

Because of the nature of the problem, educational approaches directed toward alcoholism control are extremely slow to take root. Yet, as the pilot study at Roosevelt and the subsequent programs in five other chest disease hospitals have demonstrated, educational group discussion meetings for tuberculous alcoholics can become an effective tool in helping such patients recover. But education must be based upon factual information, objectively considered, not introduced upon emotional grounds. The recoveries of the patients may also serve to focus attention upon the need to establish treatment centers in the community where all direct or indirect victims of chronic alcoholism may secure information and assistance.

The State Department of Health, through grants-in-aid to participating public and private hospitals, has established five full-time and three part-time out-patient alcoholism treatment centers in the state. These facilities provide therapeutic resources for all affected by alcoholism. They can be especially helpful to the indirect victim, the deeply troubled non-alcoholic spouse who may be just as emotionally upset or otherwise as sick as the alcoholic marriage partner. These persons need to understand and accept alcoholism as an illness. Some form of treatment is indicated for them. Particularly is this true of wives whose alcoholic husbands have stopped drinking.

Censure, moralizing, disciplinary and punitive measures are met by the hospitalized patient with passive if not open resistance. These methods have never been effective for long term control. Yet, there are times when recalcitrant or otherwise uncooperative patients may require discipline and need to be placed in a security room to protect themselves as well as others. These patients often misinterpret kindness and other considerate acts as weakness. A show of firmness may instill in them a greater respect for treatment procedures and acceptance of hospitalization and rehabilitative therapy in a more tractable manner.

Once the disease of alcoholism in the patient has been determined, he is a person doubly afflicted, and while treatment must be administered concurrently, each of the disease entities requires specialized therapy. For tuberculosis control, treatment emphasis is upon the etiology of the disease; in alcoholism, lack of conclusive or proven etiological processes compels the use of a remedial treatment approach.

In the treatment of tuberculosis, the medical approach is primary. In alcoholism, the treatment emphasis shifts from one of primary medical concern in the acute or hangover stage to one of mobilization of psychological forces needed to establish permanent recovery.

Were it possible to accomplish it effectively, it is not enough to cut off the problem drinker's supply of alcohol. It is possible to have the patient under control, but this is no assurance that his alcoholism is under control. It is necessary to help the alcoholic to live willingly without alcohol after leaving the hospital. While you cannot isolate him from the temptation to drink, he may be insulated against it.

Because he is the voice of authority, the doctor should initiate the treatment program. But after the

patient is sober and some degree of physical stability is established, the social worker or others, who by training and experience are qualified to counsel, may assume the responsibility for assisting the patient to establish his personal recovery.

It has been my experience that patients show little real knowledge of either tuberculosis or alcoholism. This would indicate that when an attempt is made to explain, the explanation should be in simple terms.

Tuberculous persons with chronic alcoholism give many reasons why and how they contacted tuberculosis. Some of these reasons are pure fantasy. Although not always apparent and open to view, there is generally a feeling of shame and guilt with tuberculosis. The non-alcoholic may eventually find it possible to accept his tuberculous condition as a treatable illness, though guilt and shame persist. Most alcoholics find it impossible to accept chronic alcoholism as something separate and apart from tuberculosis. They may learn to accept tuberculosis, but unless there is insight they cannot, without treatment and guidance, accept their alcoholism as an illness. Chronically ill patients are generally sensitive to their sickness, but the hospitalized tuberculous alcoholic feels not only stigma but is extremely fearful of ridicule, especially by his fellow patients whose esteem he wants and needs. Group identification and personal acceptance by other patients may be more highly prized and cherished than the professional concern and interest manifested by hospital personnel. Because of this, it is extremely difficult for him to accept therapy for his alcoholism.

In hospitals where the emphasis is upon treatment for a specific physiological disease, tuberculosis, for example, hospital personnel, trained in the disciplines characteristic to the treatment of this illness, are primarily concerned with inactivating the particular disease process. Most generally, they do not go in for specialized treatment directed toward resolving personal behavior problems. Yet, if the tuberculosis of the alcoholic is to be kept under control after release from confinement, greater emphasis must be placed upon need for treating both tuberculosis and chronic alcoholism during hospitalization.

Patient Selection

In those chest disease hospitals where the State Department of Health conducts weekly group educational meetings, patients are selected by the medical director or some other person whom he designates. These persons are able to convey to the patient by advisement, rather than coercion, his need for rehabilitative treatment. To be most effective, notifying the patient that he is to undergo treatment for chronic alcoholism should come from the physician. His voice lends dignity to the concept of alcoholism as a disease. Even though the patient may be recalcitrant or seem otherwise incapable of accepting without resentment the treatment prescribed, it is not likely he will ignore the wishes of the doctor or too strenuously question his authority.

Patient selection is also based upon fact finding and social histories which show patterns of excessive or uncontrollable drinking behavior. One of the most effective methods for selecting these patients is through the social history sheet from data obtained at the time of admission.

Because the alcoholic is notorious for rationalizing his drinking behavior or the extent and consequences

(Continued on page 25)

A feature designed to help you keep posted on developments in the field of alcoholism.

RALEIGH, N. C.: Once again this summer the NCARP will conduct Summer Studies on Facts About Alcohol at several North Carolina Colleges. Sessions are scheduled at East Carolina College in Greenville June 11-21; North Carolina College in Durham June 11-21; and St. Andrews Presbyterian College in Laurinburg August 6-24. The course of study, which carries college credit, is designed especially for teachers and prospective teachers. Applications for admission and other correspondence should be addressed to THE DIRECTOR OF SUMMER SESSION at any of the three colleges.

WARSAW, POLAND: The European Institute for the Prevention and Treatment of Alcoholism will be held in Warsaw, Poland June 11-22. Topics such as the problem of alcoholism in Poland and alcoholism problems in transport and industry are expected to be on the agenda. Mr. Archer Tongue is director of the institute.

BUTNER, N. C.: A psychiatric hospital that will house over 600 federal prisoners will be built in the near future at Butner, Governor Terry Sanford announced recently. The Governor's announcement followed a vote by the State Hospitals Board of Control to donate 1,000 acres of land at Butner to the Federal Government for construction of the facility. The Federal Government subsequently gave their approval for construction of the hospital. In addition to serving as a psychiatric treatment center for federal prisoners, the hospital will be the center of research in mental illness and rehabilitation. Staff members will work closely with the psychiatric departments of the University of North Carolina and Duke University. Construction of the hospital is scheduled to begin sometime this summer.

RALEIGH, N. C.: The NCARP sponsored an exhibit at the annual meeting of the North Carolina Medical Society held in Raleigh May 6-9. The theme of the display was "Hope and Help For the Alcoholic."

BLOOMINGTON, INDIANA: A workshop on Problems of Alcohol and Alcoholism Education is scheduled to be held June 4-14 at Indiana University in Bloomington. Sponsored jointly by the Division of Alcoholism, Indiana Department of Mental Health, and the School of Health, Physical Education and Recreation at Indiana University, the workshop will be of special interest to social workers, nurses and other medical personnel, clergymen, industrial and community leaders and other persons working with alcoholics.

WINSTON-SALEM, N. C.: The Alcoholism Program of Forsyth County recently increased its out-patient treatment facilities by the addition of an evening clinic consisting of group therapy sessions. The clinic is under the direction of Dr. John M. Pixley of the Department of Psychiatry, Bowman Gray School of Medicine of Wake Forest College in Winston-Salem.

LITTLE ROCK, ARKANSAS: The Arkansas Commission on Alcoholism held its fifth annual clergy seminar and workshop at the Albert Pike Hotel in Little Rock May 8 and 9. Leaders of the workshop were Dr. William B. Oglesby, Jr., of Union Theological Seminary in Richmond, Virginia; Dr. John N. DeFoore, Pastor of the First Baptist Church in Waco, Texas; and John Park Lee of New York City, Director of Welfare Agencies of the United Presbyterian Church.

BOSTON, MASSACHUSETTS: John Hancock Hall in Boston was the scene of the thirteenth conference on alcoholism on May 15. Sponsored by the Boston Committee on Alcoholism, Inc., the meeting had as its theme "Approaches Toward Prevention."

CAPON SPRINGS, WEST VIRGINIA: The National Association of Flynn Christian Fellowship Homes, Inc. held its annual conference on alcoholism May 15-17 in Capon Springs. The theme of the conference was "Relating Physical, Mental and Spiritual Therapy in Treating the Alcoholic." Mr. George L. Huden, Director of Alcoholic Rehabilitation in the North Carolina Prison Department, was Master of Ceremonies at the conference. The Flynn homes are non-denominational, non-profit facilities, and there are now 22 of them in 14 cities in the United States. A Flynn Christian Fellowship Home has recently been opened at 506 Cutler Street in Raleigh and in Asheville at 182 Cumberland Avenue. The facility provides a place for homeless alcoholics to live until they have located a job and established themselves in the community.

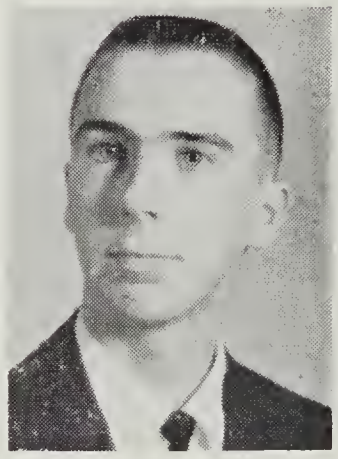
RALEIGH, N. C.: On April 26, the Raleigh Intergroup fellowship of Alcoholics Anonymous sponsored an open meeting at Josephus Daniels Junior High School. A large crowd of community leaders, AA members and other interested persons from all over the state was on hand to hear Dick C. of Robesonia, Pennsylvania, director of Chit Chat Farms and editor of the weekly publication, **Chit Chat,** and Father Frederick Lawrence from Newark, New Jersey.

CHESTNUT HILL, MASSACHUSETTS: The School of Education at Boston College, in cooperation with the Massachusetts Department of Education and the Massachusetts Division of Alcoholism, will sponsor a summer institute on "Alcohol Education in Secondary Schools" June 26-28. The Institute is primarily designed to help educators teach effectively about alcohol.

RALEIGH, N. C.: Three NCARP staff members participated recently in Governor Terry Sanford's Mental Health Council presentation in Raleigh. Associate director Dr. Norbert L. Kelly and educational director George H. Adams spoke on educational, informational and out-patient services of the Program. Dr. Kelly also presented thoughts on expansion of community alcoholism programs in the future. Medical director Dr. Donald Macdonald discussed in-patient treatment for alcoholics, current research at the Alcoholic Rehabilitation Center at Butner, and future plans for treatment methods.

Inventory is pleased to participate in the Orange County Council on Alcoholism's Essay Contest among the Chapel Hill and Orange County high schools through publication of this essay. Five winners from the participating schools were submitted by the Council for consideration. This one was selected on the basis of suitability for publication in *Inventory* as judged by the editor and assistant editor. *Inventory* salutes Mr. Johnston, the Council and the four other winners, with regrets that their essays could not also be published.

YOUR HEALTH and ALCOHOL



BY DOUGLAS JOHNSTON

STUDENT, CHAPEL HILL HIGH SCHOOL
CHAPEL HILL, N. C.

IT was published once, not long ago, that too many people's reaction to the problems posed by alcohol, and more particularly, alcoholics, is "reject, rebuke, and ridicule." This is one set of "3 R's" it would be unwise to follow because alcoholism affects us as well as the alcoholic.

One may ask, "How does it affect me? Why is it my responsibility?" The answer to these questions may be found in this familiar saying: "A chain is only as good as its weakest link."

When applying this saying to the problem of alcoholism, the entire chain represents all of society and the particular weak links of the chain represent the alcoholics. If we do nothing to strengthen these weak links, we will only be hurting ourselves. Since the problem affects all of society, it is the responsibility of everyone to do his share in solving the problem. This includes, first of all, trying to understand the problem.

One step in understanding is to recognize that alcoholism is but a symptom of mental illness. This mentally ill person turns to the bottle as his type of "solution" to the problems that confront him. This is where the second stage of the problem enters. As the consumption of alcohol continues, it becomes increasingly harder not to rely on the bottle. The period of time between drinks gets shorter and shorter until the time comes that the only way the alcoholic can be cured is by outside help. One of the best sources of outside help is personal understanding.

The Greek physician, Hippocrates, once said, "Healing is a matter of time . . . but it is sometimes a matter of opportunity." It is up to us to give the alcoholic the opportunity. Through personal understanding, rehabilitation, and medical help, the alcoholic can assume a valuable place in society.

Of course, there are ways of preventing the problem from reaching such stages in the first place. Of all the methods of prevention yet tried, education has proved to be number one. Education helps the potential alcoholic see that alcohol does not provide any of the answers to his problems. It may give him the self-confidence to seek the solution for himself. Education also shows that alcoholism is a public health problem and, hence, a public responsibility.

Alcoholism, as well as other problems, does not cease to exist merely because it is ignored. Every citizen has an obligation to do his part for the improvement of society.

SPECIAL WEEK ON AGING in NORTH CAROLINA

BY MARGARET A. CHEARS
EXECUTIVE SECRETARY

NORTH Carolina will honor its older citizens the week of July 15-21, 1962, the annual Special Week on Aging, proclaimed by Governor Terry Sanford. The week is sponsored by the Governor's Coordinating Committee on Aging.

North Carolina has approximately 335,000 persons 65 years of age and over and this segment of our population is rapidly increasing. The total population of the State doubled from 1910 to 1960, while the number of older people increased fourfold during this half-century period. Even more striking is the fact that this age group doubled during the two decades 1940-1960.

As the 65 and over population increases, more attention should be given to their problems, needs, and opportunities. This should be at the state, national, and local levels to meet the challenge of this age group.

According to Dr. Ellen Winston, State Commissioner of Public Welfare and chairman of the Governor's Coordinating Committee, "The happiness and welfare of our older citizens is one of the primary concerns of the public welfare program."

"Not only do many of these elderly persons need financial assistance, but an increasing number seek nonfinancial assistance in terms of help in planning to continue to live normally in their own homes. Through skilled help, older persons and their families receive assistance in making workable plans which satisfy the needs of both family and aged relatives."

GOVERNOR TERRY SANFORD

During this Special Week, the health, happiness, and welfare of North Carolina's aging citizens will be given special consideration.

A fifteen member Governor's Coordinating Committee on Aging, appointed by Gov. Terry Sanford, consists of Dr. Ellen Winston, commissioner of the State Board of Public Welfare, chairman; Dr. J. W. R. Norton, State Health Director, vice chairman; Ralph Andrews, director of the North Carolina Recreation Commission; Miss Margaret Blee, professor, Public Health Nursing, University of North Carolina, Chapel Hill; E. N. Brower, president of Brower Mills, Inc., Hope Mills; Frank Crane, commissioner, State Department of Labor; Dr. Catherine Dennis, State supervisor of home economics education; Dr. Robert H. Dovenmuehle, Center for the Study of Aging, Durham; Dr. Eugene A. Hargrove, commissioner of mental health, State Hospitals Board of Control; Mrs. Elizabeth

(Continued on page 18)

If the alcoholic is aware of hurdles that he may encounter in recovering from his illness, he will be better able to maintain his sobriety.

BY R. W. FRASER, M.A.

ASSOCIATE DIRECTOR OF TREATMENT
ALCOHOLISM FOUNDATION OF ALBERTA

Reprinted from PROGRESS

MANY alcoholics establish and maintain sobriety for considerable periods of time, but then return to drinking. Frequently this occurs because they have not anticipated nor prepared for some of the hurdles and difficulties they will experience while recovering from alcoholism.

Every person wants rewards and satisfactions as a result of his efforts. The alcoholic expects satisfactions from sobriety, but if these are not sufficient, he may return to drinking. It is hard to say how much satisfaction will be considered "sufficient"—and alcoholics frequently expect more than is realistic. If, however, the newly recovering alcoholic has in advance a realistic idea of some of the probable "dissatisfaction-producing" situations he will encounter as his sobriety extends, he will be better able to deal with his feelings and retain his sobriety more successfully.

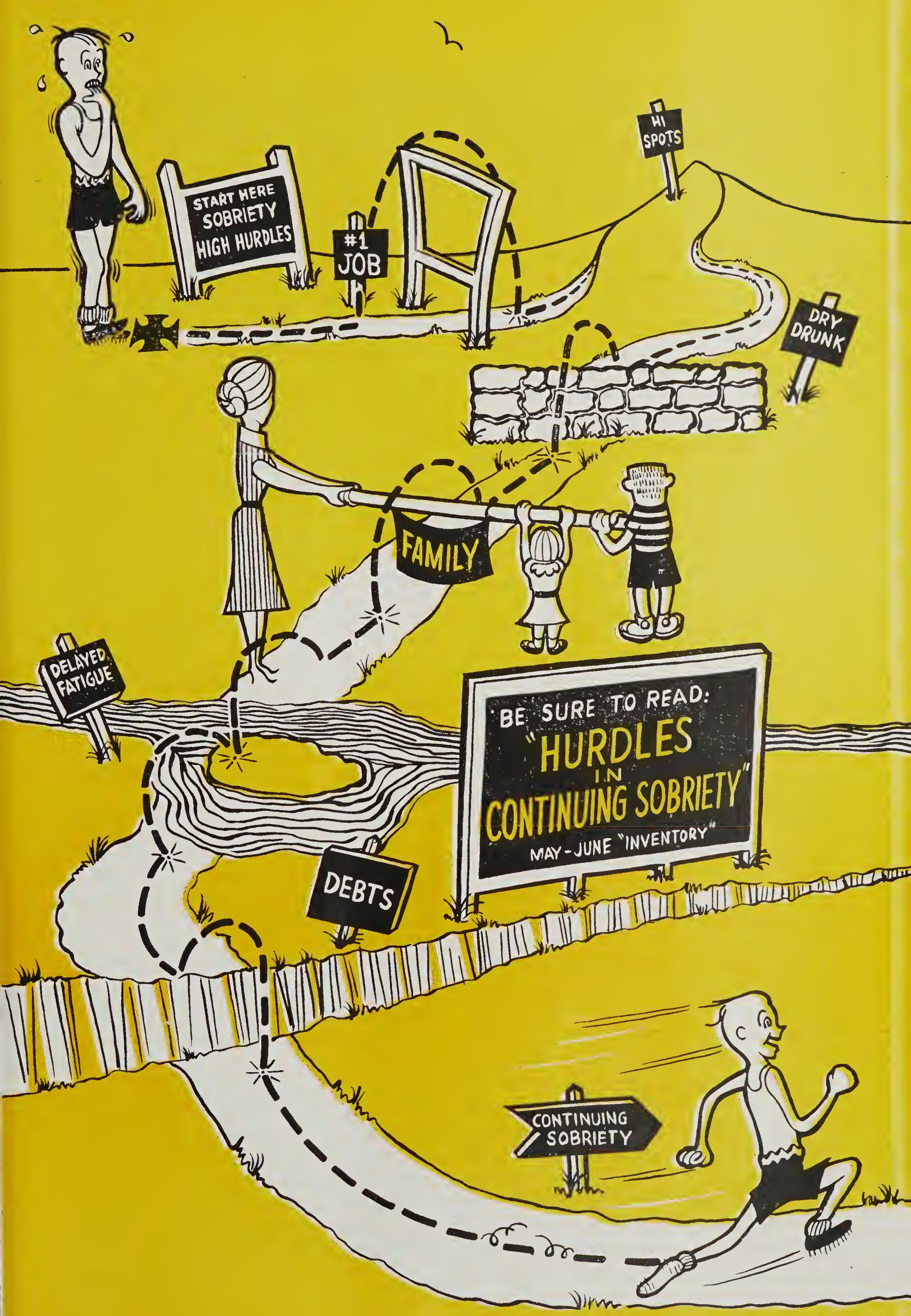
Individual problems and difficulties which may threaten sobriety will vary considerably, but there are some factors which are common to nearly all middle and advanced-stage alcoholics. Below are a few of them:

1. When an alcoholic decides to stop drinking it is because he is dissatisfied with many of the consequences of his drinking. When he makes this decision, he feels a little better—all people obtain a certain satisfaction in making a decision to face a problem. However, the alcoholic is probably in poor physical and emotional shape, and as he starts a period without alcohol, he begins to feel worse instead of better. These feelings of satisfaction are short-lived and are soon replaced by feelings of dissatisfaction and distress. As his physical condition slowly improves and as he realizes that his whole world hasn't quite collapsed around his ears, his emotional condition also improves. In addition, he is actually maintaining his sobriety and some hope and self-confidence return. By carrying out a long-deferred decision to stop drinking, the alcoholic experiences an increase in feelings of satisfaction.

2. Two to three months of sobriety is often enough to convince the alcoholic that he "has it made" and no more special effort in the way of treatment or attendance at AA is necessary. He may decide it is quite safe for him to go in and have a "juice" with the boys. He is letting his guard down and the thought "One won't do me any harm" is close. This period can be unsettling to the recovering alcoholic. He hits a plateau—feelings of satisfaction from sobriety are no longer increasing, so the feeling that he is progressing may be lost.

Several other factors make this a rather dangerous period:

The alcoholic has been sober now long enough to appreciate his situation more clearly—to realize that the road back is long, and may be slow and bumpy in places. He may begin to doubt that he can really regain a satisfactory amount of what he has lost or he will begin to feel frustrated and resentful about how long it may


START HERE
SOBRIETY
HIGH HURDLES
#1
JOB
HI
SPOTS
DRY
DRUNK
FAMILY
DELAYED
FATIGUE
BE SURE TO READ:
"HURDLES
IN
CONTINUING SOBRIETY"
MAY-JUNE "INVENTORY"
DEBTS
CONTINUING
SOBRIETY

take.

Others start making demands on him. He has been sober for a while, but there is less approval voiced of this accomplishment and perhaps more disapproval of other things he is, or is not doing.

Dwelling on past losses may reduce his recently regained feelings of self-confidence and hope.

3. The combination of these factors often causes a marked decrease of satisfaction. Sobriety hardly seems worth it. Restlessness, despondency, irritability, strong temptation to drink, "I might as well be drunk as the way I am," "I'm no good sober, either," are common expressions and feelings during this phase. The alcoholic tends to avoid others during this period, because he feels that they are critical of him and doubt his ability to make a come-back. He may wish to avoid treatment interviews or AA meetings. Often he will rationalize his withdrawal from treatment or missed AA meetings by saying he "doesn't want to be a nuisance" or he "doesn't want to bother anyone." At a time when he most needs support and re-inforcement, he feels too guilty to seek it.

4. A dull "what's the use?" attitude may now develop. He will feel unhappy and depressed about the present and the future. The thought, "A drink or two would sure help me along," may be a constant threat. Rationalizations may appear such as, "A drink or two would help me get a job," "I could sell better with one under my belt," "A drink would give me a good night's sleep and cut down this jitteriness," etc.

5. Next comes a period of reorganization, of facing what has to be done and deciding how to do it—a period of getting accustomed again to living with the tensions and frustrations of everyday life. Along about now, like a person who gets a "second wind," he again starts to experience a few satisfactions from sobriety. From then on there will be a slow, steady gain in the overall satisfactions from sober living, until he reaches an average level and average balance between rewards and dissatisfactions in his day to day living. He must, however, be prepared to handle, cold sober, for the rest of his life, the difficulties, frustrations, disappointments, irritations and hurts that many non-problem social drinkers handle with the help of a drink or two.

Following are brief outlines of some of the hurdles the alcoholic will have to face and overcome if he wishes to maintain sobriety.

Unemployment

Often the alcoholic has no job and his work record in the past several years will be more of a detriment than a help in finding one. He may be turned down many times and become discouraged and reluctant to face the risk of further rejections. He should be prepared for this. Finding a steady job won't be easy.

One of the most important things for the advanced alcoholic to do is to re-establish a record of job stability. Therefore, he may be well advised to keep his employment sights relatively low; to find a bread and butter job and hold it for 6 to 12 months. He will then have a period of steady employment to refer to when a better job opportunity comes along.

Debts

By the time the alcoholic does make a serious attempt to stop drinking he may have little money and lots of debts. The alcoholic must discharge his debts, but he cannot do this in a few months—it may take several years. After he secures

steady employment and can budget his income, he should plan to discharge his debts gradually.

Attitude of Children

The alcoholic's children may have learned during the course of his illness to disregard him. It will take a while for them to unlearn this. During the first year of his sobriety, his children may act toward him in ways that he considers disrespectful or they will seem to show little regard for his opinion. During the last few years, they have learned to turn to their mother as the authority in most things concerning the family. Naturally, as father and husband, the alcoholic resents his lost role. He must, however, be prepared to be patient with his children and give them plenty of time to recover their respect and love for him. As his sobriety extends, this will occur. He should guard against temper outbursts and authoritative demands for proper respect, as these will only impede the change in the children.

Attitude of the Spouse

Many an alcoholic who is doing a good job of maintaining sobriety feels that his wife is unnecessarily anxious about him and is always ready to worry for fear he is going to "slip." His irritation about this, if he isn't careful, can build to the point where he begins to feel that he might as well "give her something to worry about." An alcoholic should try to remember that his wife's anxiety is the result of long and painful experience and also that much of it is based on genuine concern for him. It is natural for her to worry when he is late getting home, or when he is under tension of some kind, and he should try to accept this without resentment, and reassure her.

As his period of sobriety increases, she will gain increasing confidence. Only his continued sobriety can break her habit of worrying about whether he is going to "fall off".

Frequently after several months of sobriety, marital friction will develop in the home of the recovering alcoholic over "who is running the house" or "who is in control of family affairs." Often, as the husband's alcoholism progressed, the wife has had to take over control of the household in order to keep the family together. She may have become accustomed to making most of the decisions and may find it difficult to give up this role.

Wives of alcoholics frequently say of their drinking husband "he's a wonderful husband when he is sober. If he would only quit drinking our marriage would be perfect." When sobriety does occur, a wife may fail to realize that her husband is trying his best to make up for his behavior during drinking. He is bending over backwards to be pleasant and considerate—he does not argue, or contradict, or demand his own way.

After he has maintained sobriety for a period of time, he doesn't need to be continuously atoning or agreeing with everything in order to prove he is a nice person. In other words, when permanently sober, he reverts to being an ordinary rather than perfect husband. A wife may be accustomed to a husband who is belligerent and demanding when drunk, but she is often not prepared for behavior which is demanding or critical when he is sober. Readjusting to this "new person" may be difficult for her. It is often helpful, at this stage, for both partners to have professional counseling. This will facilitate the necessary transition from the presobriety disorder of the marriage to a comfortable, enduring relationship.

(Continued on page 26)

The author contends that alcohol-drinking earthlings are in search of truth and happiness in this unearthly bit of whimsey from MEF.

A Report to the Martian Academy on:

EARTH'S CURIOUS DRINKING CULT

BY R. Z.
COUNCIL BLUFFS, IOWA

Reprinted from the AA Grapevine

FELLOW members of the Martian Academy:

My report on the first Mars expedition to planet Earth would not be complete without brief mention of the curious custom which centers around a substance which Earth-people call alcohol. Although alcohol is unknown here on Mars (our planet life and atmosphere do not contain the necessary elements to manufacture it), it is consumed in many forms on Earth.

Alcohol is a colorless, volatile liquid. Since it causes a burning sensation on the tongue and in the throat when imbibed, Earth-people of both sexes drink alcohol with intense fervor, gathering for the ceremony in dimly lit temples where they must raise their voices to be heard over the sounds from automatic music machines.

The alcohol is dispensed by a Grand Mogul whose robe of authority consists of a white cloth tied about the waist and hanging freely to the knees. In larger halls he is assisted by hand-maidens who wear similar white aprons.

The Mogul officiates at a mahogany altar backed with colored lights, ornaments and rows of glass containers of varying shapes, but all filled with the solution which he dispenses. An alcoholic potion is prepared in small glasses by the Mogul and handed to the slavish subjects over the barricade. This evidently symbolizes his exclusive and elevated role.

In exchange for his quantity of alcohol, the drinker hands the Mogul one of the tokens of metal or paper which are prized so highly by Earth-people. The large number of these tokens which Earth-people exchange for drinks of alcohol is evidence of the importance which the drinking plays in their lives.

One member of the MEF (Martian Expeditionary Force) sampled

some of the alcohol and reported decidedly unpleasant effects: dizziness, difficulty in speech articulation, cloudy memory, a lethargy in the limbs.

The Earth-men who were acting as our hosts insisted that the volunteer try additional samples. There were remarks about a bird (a type of Earth-creature) flying on one wing. Our volunteer protested, but not wanting to be impolite, he allowed additional doses to be administered. What followed is outside the scope of this report; in brief, our poor companion had to be carried back to our spaceship to recover. He reported, upon regaining consciousness, that the experience was somewhat like the illness we often endure on Mars during the annual advance of the ice cap, when we have to resort to artificial foods.

We concluded that alcohol-drinking is bound up in some way with the search for Truth and Happiness which is such an obsession with Earth-people. Some alcohol-drinkers are more devout and persevering in this search than others, and their ecstasy often reaches a trance-like state, at which time they fall to the ground unconscious. Others make their way forth from the hall, uttering incoherent prayers and propelling themselves erratically in machines known as automobiles.

The alcohol persuasion leads a few to a monastic way of life. They renounce family and friends, their vocation and all wordly pleasures, to carry out their devotionals. Some of these retire from human company for days at a time, to perform secret rites which, we are told, alternate between lengthy trances and disordered wakefulness.

A word must be said about a small but growing sect of comparatively recent origin made up of those who have attained the rank of High Prophets of the alcohol cult.

They evidently have found the answers which others are seeking in drinking alcohol. The knowledge was gained through such suffering and hardship that it is coveted and passed on only to those whose similar experience has led them to the threshold of understanding. These chosen ones meet surreptitiously, refer to each other by first names only, and their membership in the sect is known only to other members.

While each of them was at one time a dedicated practitioner of the alcohol-drinking ritual, they now joyfully shun alcohol on all occasions and devote much time to instructing novices in the secrets of the order.

They speak frequently of their search for Truth and Happiness but under their new doctrine these treasures are found everywhere *except* in alcohol. This radical belief is regarded as subversive by many Earth-people, so members of the sect go about in anonymity. Their anonymity is not perfect; we noted they wore expressions of serenity seldom observed on the faces of other Earth-people, and they seemed to retain admirable composure at times when others were wringing their hands over the vexing problems of Earth-life.

Further Study Recommended

It is our recommendation that the Martian Academy undertake further study of the alcohol cult on Earth to learn to what extent it may be responsible for the chaotic social conditions on that unfortunate planet. When our next expedition is dispatched—carrying colonists and missionaries to teach the Martian Way of Life—we must be equipped with as much knowledge as possible to help us get along peacefully with the Earth-people. If, indeed, it is possible to get alone peacefully at all with people of such peculiar habits.

SPECIAL WEEK ON AGING

CONTINUED FROM PAGE 10

Hughey, State Librarian; Dr. Wingate M. Johnson, Bowman Gray School of Medicine, Winston-Salem; Col. Henry E. Kendall, chairman, Employment Security Commission; Dr. Harold D. Meyer, chairman, recreation curriculum, University of North Carolina, Chapel Hill; David S. Weaver, School of Agriculture, North Carolina State College; Mrs. Annie May Pemberton, State Board of Public Welfare, secretary; Miss Margaret A. Chears, executive secretary; and Raymond J. Jeffreys, part-time consultant.

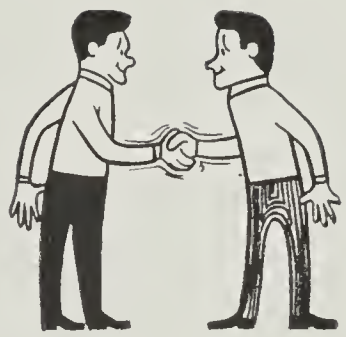
The Governor's Coordinating Committee is now engaged in several important projects. One is a pilot project to study church activities of the older people. The Raleigh Ministerial Association and Raleigh Council of Churches are sponsoring this survey. Questionnaires have been sent to churches asking the contributions of senior citizens.

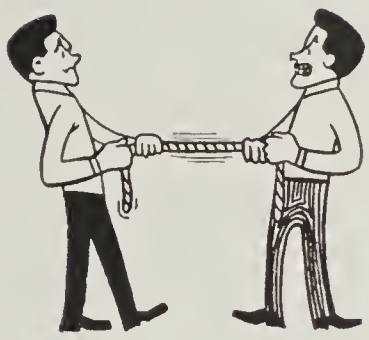
The Friendly Visitor project is about to get started. A pamphlet telling how to organize the program, is now at the print shop and will be ready for release in early July.

The Coordinating Committee is also working on a county organization bulletin which will be of assistance in planning and coordinating work in the community. It is hoped that there will soon be 100 active county committees.

Activities of the county groups include workshops on aging, at which members of the Governor's Committee serve as speakers, resource persons, panel moderators, or in other capacities. Special attention is given to the recognition of potential resources of older citizens, and to alerting the public to the need for strengthening services essential to the well-being of the older population.

Strengths and Barriers of Communication within the COMMUNITY STRUCTURE





BY NORBERT L. KELLY, Ph.D.

ASSOCIATE DIRECTOR
NORTH CAROLINA
ALCOHOLIC REHABILITATION PROGRAM

The educator must be aware of certain facts about his audiences and messages in order to establish an effective communicational process.

TO a very great extent, one of the chief barriers to education is the very thing we are trying to change —the public image of alcoholism. Perhaps this should be put in the plural and referred to as the public *images* of alcoholism.

In many of the communities I've observed, I've become aware of at least three segments of public opinion relative to the illness. One segment vehemently rejects the alcoholic condition as an illness. A second accepts it as a health problem. The third segment is largely indifferent to the condition's existence.

Over the years, there appears to be an opinion movement from segments one and three, rejection and indifference, toward understanding and defining alcoholism as a health problem. But the movement is slow.

If there is any validity in this observed, but crude, typology of potential audiences, it may serve as a basis for educational planning. A pertinent question would be: Where shall we concentrate our efforts? On those who rigidly oppose our basic assumption? Or on those who are seemingly unconcerned with the illness? How much effort should we expend on those who think as we do?

Posing these questions leads me to emphasize a point that is fundamental to efficient communication: We must know as fully and concretely as possible the audiences with which we work. We must know their attitudes and value systems and fit our messages to them so our efforts do not wall-off the audience.

Some educators unfortunately are inclined to see a direct, simple relationship between communicator and audience. They see the audience before them as though it existed in a vacuum, untouched by social living, free of all predispositions, or as a group collectively just waiting to

This article consists of the second half of a speech given by Dr. Kelly at a regional conference on "Developing a State-Wide Alcohol Education Program" held in Birmingham, Alabama, January 30-February 1. The first half appeared in the preceeding issue of Inventory.

be spoon-fed the "right word."

Many of you know this just isn't an accurate view—whether the audience be mass or face-to-face. People don't shuck off their attitudes and values when they expose themselves to communication. In fact, these predispositions are largely determinative of the kind of audience you have.

The processes of selective exposure, selective perception, and selective retention are very germane to the success of any educational endeavor. Most people tend to expose themselves selectively to community education or communication in conformity with views they already hold. We tend to avoid communications which are threatening to our attitude or value systems, or with which we are uninterested or unsympathetic. We tend to be interested in those things that already are of interest to us, not in the new.

Liberals tend to seek out liberal messages in the various media; conservatives seek the conservative viewpoint consistently. Seldom does any of them cross over into the communication reservoir of the other. If such should happen, and the individual finds himself exposed to unsympathetic material, the process of selective perception may well occur. That is, it is highly likely that the individual will so perceive, so distort, the material he is being presented that he is able to harmonize it with his existent attitude and value systems. Haven't we all had our words twisted to mean what a hearer wants to hear, not what we actually said?

There is evidence also that tends to show that we retain sympathetic material much longer than material that is not in consonance with our predispositions.

While these principles focusing on the selection process are derived from mass media research, it is my experience that they are also applicable to face-to-face communication, including the group process. Of course, in face-to-face group situations, one has a better chance of dealing with such handicaps.

I don't want to give the impression that all people rigidly maintain forever their current mental customs. This, of course, is not true. People do change; attitudes and values change. Behavior can be modified through communication. Rural technologists and rural sociologists have studied such behavioral change in rural areas and have labeled the process "diffusion," a term borrowed from cultural anthropology.

Several points evolve from a study of the diffusion process, though it is largely concerned with the adoption of technological innovations.

The first is that it is through the mass media that many rural people come in contact with potential innovations. Whether or not an individual actually adopts an innovation, however, is largely dependent upon the reactions of his primary groups.

A second important discovery emerging from diffusion study relates to the existence of the Innovator in the community. If we may tentatively generalize from this latter point, we might say that in any social system potentially there are people who are in advance of the thinking of their communities and are more apt to change quickly.

The question now becomes: How do we locate these potential innovators in the social structure?

In a sense, the Innovator is akin to the Opinion Leader discovered by research in political communication. A number of studies have concluded that individuals are more influenced by opinion leaders than they are directly by mass communications. The

leaders, however, expose themselves more to mass communications and carry the messages back to their followers. They act as a transmission belt for ideas which may bring about potential change.

Though it is quite possible that these opinion leaders may also sometimes use their influence for reinforcement instead of change, it would appear that it would be valuable to know where they exist in the community structure.

I believe it would be of especial value, for example, to know who are the opinion leaders among a community's lower socio-economic classes. This is a category in almost every community that is usually hard to reach. People with little education and inferior life chances are usually not found in an audience for serious subject matter.

Perhaps relevant questions here are: What are the group affiliations of the lower social classes? Can they be reached through organized groups? Or do the opinion leaders function largely through informal groupings? How can the alcoholism agency cooperate with other agencies or programs in reaching this segment of the community?

With five to six million alcoholics in our country, I believe there are large numbers of people in every sizeable community awaiting or needing knowledge about this illness. Some are frightened by it. Some are angered by it. I'm referring to the alcoholic's primary groups: his immediate family, relatives, friends, his neighbors, and work-groups.

These are community groups that have a stake in this illness. Many of them are already motivated to learn about it because of their interest in the welfare of the alcoholic and their desire to aid in his recovery. They constitute a community asset. Our problem with them is largely educational case finding.

Others, however, create a climate of opinion around the alcoholic which may impede or threaten his recovery. They constitute a real barrier to education. They don't want to be reached. A fundamental educational question, then, is how do we reach those who are unmotivated in order to help the alcoholic in his struggle for health?

Alcoholics themselves, of course, are a key audience. Yet I hardly need mention that they present a stiff barrier to understanding their illness. The recovering alcoholic, conversely, is frequently a major support to alcoholism education in the community. In their eagerness, some alcoholics, in fact could use a gentle reign.

Within the framework of interest in alcoholism, I've found many professional people to be responsive au-

diences and, not infrequently, facilitators of alcoholism education. I would include here many social workers, health educators, a few but increasing number of physicians, some law-enforcement officers, ministers, and a limited number of public school officials and teachers. The educator who knows his community will know these people as individuals and involve their interest and ability to the best advantage.

If interest in a subject is considered a strength, then the youth of the community must be so considered. Alcohol education, in this case, is a topic of major interest to many young people. And by no means would I rule out alcoholism education, also. Many are interested in it. In terms of prevention, this motivation should be met with well-planned programs.

One final word about the audience. Many organizations have found the use of captive audiences to be more efficient and rewarding than the general audience.

In employing the captive group, you are, first of all, assured of an audience. One never knows if a general audience will "show up." Sometimes it doesn't. Again, with a captive group, you stand a chance of reaching those whom you might not otherwise contact. Also, this format permits the opportunity of studying the group and getting to know its predominant attitudes and values—points emphasized previously.

In this discussion of audiences that facilitate or impede education, I have referred to the several public images of alcoholism and outlined a rough audience typology. The importance of knowing as well as possible each audience and not directly violating its value systems was emphasized. The significance of predispositions as manifested in selective exposure to communication, in selective perception, and selective retention was mentioned. Certain key audiences were discussed because of their centrality to the illness: the primary groups surrounding the alcoholic, the alcoholic himself, professionals concerned with the illness, and youth.

It was also pointed out that the lower socio-economic classes present a particularly difficult barrier to educational effort because of their inaccessibility.

The roles of the Opinion Leader and the Innovator were suggested for study and as potential strengths in community educational work. Certain questions were raised concerning these roles.

The utility of the captive group was underscored.

Knowing One's Audience

As I move into the final section of this paper and attempt to raise certain points concerning communicational content as a strength or barrier, I want to return briefly to a statement made about the importance of knowing one's audience—whether it be mass or face-to-face.

Knowing one's audience, as I have stressed, gives you an opportunity to orient the content of your material so you don't violate the group's values. From the standpoint of educational content, I want to illustrate now how such violation may impede alcoholism education and actually boomerang.

Several years ago, a psychiatrist, psychologist and I, a sociologist, participated in an alcoholism institute in a southern state. One of the three —not the sociologist—had recently come to this country. He was still in the process of learning our culture. He hadn't, as then, learned our taboos. This individual gave the final talk on the morning program. As a

part of his presentation, and for the purpose of illustration, he drew on a blackboard the human body, both male and female. To emphasize certain portions of his discussion, he emphasized also in his drawings certain tabooed anatomical details—organs that most Americans don't make much of in public discussion.

As his chalk graphically stressed his points, the reaction of the audience was unquestionably audible. His audience was composed entirely of ministers, their wives, and workers of a particular church.

I was standing near the door as they filed out at the end of the lecture. Disapproval of the drawings was voiced by many. Less than half the audience returned for the afternoon session, though the program had been going well and interest had been high up to the speech described.

Not only this, but this particular church group had been greatly interested in doing something about the problem of alcoholism. The session mentioned may have been one of the factors in the dwindling of that interest. I have not heard of any activity by that group since.

A classic case of content misfit and boomerang took place during World War II. Allied psychological warfare agencies learned of Hitler's reliance on astrology in the conduct of the war. In the belief that the German people did not know of this "silliness" of their leader, our propagandists played it up hard as a weakness. "What a joker this guy Hitler is because he relies on astrology. How crazy can you get!"

Research, after the war, revealed that a large section of the German public believed implicitly in astrology and our lampooning their leader only strengthened their belief and faith in him.

This is the sort of thing that can happen to alcoholism education if it promises too much and if the educator doesn't know his groups and fit his content accordingly.

Verbalism is the very heart of communication. This is not to overlook the very great importance of non-verbal communication, but I believe I'm safe in saying that the community alcoholism educator relies primarily upon language in his work with the public.

I have been discussing *possible* content barriers—some that can be foreseen and controlled. A barrier that is immediate and much more difficult to cope with is the "alcohol language" itself.

Unfortunately, as yet, there is little consensus in the usage of terms relative to alcoholism. The absence of a settled and accepted terminology makes for difficulty when working with a public that is looking for simple answers, that wants unqualified formulas for its problems. Lacking a consensual terminology, the educator does two things: He devises tentative, but operational, definitions upon which he bases his activity, and he silently prays that research will soon provide him with a commonly accepted set of concepts, adequately defined.

At the risk of throwing the reader into minor confusion, I might—I say I might, now, but I really won't —raise such questions as: Who is an alcoholic? Or even, who is a drinker? But we won't go into that. Or must we?

Despite the lack of language consensus and the necessity of operating on tentative conclusions, I make my next point unequivocally. The content of the material is such that I have never worked with a disinterested group nor had a disinterested audience. I believe this fundamental interest in the content of our mater-

ials to be one of our greatest strengths. The interest is understandable—given the widespread use of beverage alcohol and the prevalence of alcoholism.

Even the most difficult group I ever worked with was unquestionably interested in the problem. This was a group of tuberculous alcoholics in a sanatorium. For two solid hours I used all the knowledge and skill of group discussion techniques I knew trying to involve some fifteen of them, and got nowhere. Hardly a peep came from them. But at the end of the series of "alcoholism education discussions" they insisted that we continue.

Yes, there is a real unmet need for knowledge about this provocative illness. Certain content areas I have found to be of particular interest to specific audience types. Men are particularly interested in discussing symptomatology. Again, this may be because the custom of drinking is so widespread. Female audiences are particularly interested in the family aspects of the illness and the female alcoholic. College students ask a lot of questions about prevention and the mental health involvement in alcoholism. I've found many ministerial groups enthusiastically inquiring about what they can do. Parole officers are interested in material content that will not only help them understand their parolees with the problem, but will also guide their relationships with them. Almost any audience is interested in the effects of alcohol and the alternative symptoms to uncontrolled drinking.

As many of you very well know, a communicational message may have a "sleeper-effect." For the uninitiated, I'm not referring to any drowsiness that may be creeping over you as you read this. I am, however, directing your attention to the possibility that the result you desire from a given communication may not show up immediately. But your effort combined with other, perhaps unknown, influences may result in the desired goal sometime in the future. I mention this because it may serve to balance the sometime pessimism those of us working in alcoholism are prone to.

Now, before that other type of sleeper effect you were thinking about when I mentioned the concept really begins to make headway, I want to mention additional research findings relative to content.

First, it's been fairly well established that educational content that carries explicit conclusions tends to be more effective than content that demands the audience draw its own conclusions.

Relevant to this point, a question we might ask is: What explicit conclusions do we as educators wish to offer the public? It seems to me that this question, in turn, is related to the goals of alcoholism education. What are the goals of alcoholism education? That one has possibilities of sending you into orbit, too.

Another communicational research finding related to content may be expressed as follows: The more closely and clearly content fits the personal problems of the audience, the greater will be its appeal to the audience. This is just another way of saying that message content should be directed at meeting basic needs.

I juxtapose my final point to the previous one, for it is directly related to it. Here it is: We humans tend to respond more readily to persuasion when message content includes a suggestion for action.

This has been a discussion of the strengths and barriers within the community structure that help or hinder alcoholism education based

around the four familiar communicational elements; the communicator, media, audience and content.

The strengths of communication within the community structure may be enhanced by the careful selection of the educator—based on qualifications, skills, experience and personality—on the part of the local alcoholism agency.

One strength—a widespread felt-need for information on alcohol and alcoholism—and one barrier—the relative inaccessibility of some audiences—make the fullest use of all media of communication mandatory. Building evaluation into educational programs making use of the various media is highly recommended in order that their relative merits may be ascertained.

A pitfall to avoid is assuming that there is only "one" audience. Three major potential audiences can readily be identified within the community: those who vehemently reject the alcoholic condition as an illness, those who accept it as a health problem, and those who are largely indifferent to the condition's existence.

The content of the educational message must be tailored to the individual predispositions, attitudes and value systems of different audiences if attitudinal and behavioral change is to be effected. The process of changing attitudes and behavior may be facilitated by locating and reaching the Innovators—those people who are in advance of the thinking of their communities and are more apt to change quickly—within the community.

Experience has shown that certain specific audiences such as men, women, college students, etc. are more interested in some content areas than others. This is a strength which should be utilized by the educator in preparing the educational message.

TB AND ALCOHOLISM

CONTINUED FROM PAGE 7

of his alcoholic indulgences, information he volunteers cannot always be accepted as completely reliable. How alcohol has affected the patient as a person should be the criteria of evaluation and, whenever possible, the basic information should come from those genuinely interested in the patient's recovery.

Any history of serious drinking should be indicated and recorded at the intake interview. When the attending physician sees the patient for the first time he is then in a better position to inform the patient his treatment will be for alcoholism as well as tuberculosis. Upon first admissions, this can have a tremendous impact. Made known in the beginning that the educational meeting is considered a part of treatment, the patient will be more receptive than if told at a later date. To delay is to invite resentment and resistance.

Experience has shown that the addictive drinker can never return to social drinking. If he is a tuberculous person, a return to the alcoholic pattern not only undermines his own health, but makes him a source of infection among family, friends and associates. Case finding tells us the alcoholic has a high incidence of tuberculosis and is a major source of this disease. From experience and observation, it may be concluded that if we are to successfully control tuberculosis we must exert greater efforts to stem one of the contributors to its perpetuation, the alcoholic. Through education this may be accomplished.

It is the hope of the Department that all chest disease hospitals will eventually institute rehabilitative programs to treat concurrently the disease entities of both tuberculosis and alcoholism.

CONTINUED FROM PAGE 15

High Spots

Often alcoholics who have held their sobriety through periods of real distress and hardship will start to drink when they get a "lucky break" or when things are going well and they are regaining ground rapidly. Every recovering alcoholic should be aware that, when he has overcome many of his problems, there is a likelihood that he will start to drink. He may feel that since he has solved most of his problems and is no longer worrying as much, he should be able to take a drink or two like others and keep it under control. If he does try this, he takes the first step back to all the worries and difficulties he has just overcome.

Dry Drunks

This is an apt AA term and refers to a condition that many recovering alcoholics experience—even after substantial periods of sobriety.

A "dry drunk" is a period of several days when the alcoholic feels depressed, apprehensive, unable to sleep—for no apparent reason. As sobriety extends, these periods will occur less frequently and will be less intense. The alcoholic who is not prepared for the occurrence of a "dry drunk" may get panicky and feel that he is cracking up. The recovering alcoholic, who begins to experience one of these tension periods, should get in touch with his treatment clinic or with his AA friends or with both, and strongly resist the old habit of thinking that "a couple of drinks would settle me down."

Delayed Fatigue

During the early period of sobriety feelings of fatigue are only one of a number of distressing feelings that the alcoholic may have. These feelings become less troublesome as sobriety extends and as physical and emotional health improves. Sometimes, however, after six or twelve months of sobriety during which he has achieved better general health than he has enjoyed for years, he will experience a sudden drop in his general energy level and will feel very tired for a period of time.

Why this occurs has not been satisfactorily explained, but it is quite common among recovering alcoholics during the six to eighteen months period of sobriety, and may occur even after that. If it does occur, the alcoholic should not feel he has to try to ignore these feelings. He should get additional rest and lots of it. Wives and families of alcoholics should be made aware of this phenomenon. If the recovering alcoholic tries to ignore the feeling of acute fatigue and persists in his usual activities despite them, the whole cluster of distressing feelings common to the early period of sobriety may return. Fatigue in the alcoholic when improperly understood and managed, may possibly be the precipitating factor in the so-called "dry drunks."

Building a New Self-Image

All of us carry around a mental picture of the kind of person we are. All our various attributes, whether real or imaginary, of a physical, mental or emotional nature, are contained in our individual "self-image." A person who has developed alcoholism must obviously have a well-developed concept of himself as a drinking person. This concept is the result of years of drinking and it is reinforced by the fact that he is known to his friends as a drinking person.

When the alcoholic decides to stop drinking, an important part of his self-image is disrupted. It is very difficult for the alcoholic to begin to

change his image of himself so that he thinks of himself as a non-drinking person. He may even feel a certain hostility towards the abstainer or think of him as queer or strange. Naturally, then, he would not want to picture himself as a non-drinker. In spite of this, the alcoholic must change his self-image from "drinker" to "non-drinker" if sobriety is to be maintained without great discomfort. He must learn to accept this concept of himself as real and he must be able to say, unemotionally, in any company, on any occasion, that he does not drink. There must be no loop holes in this new picture of himself as a non-drinking person.

How to Change the Self-Image

Knowledge and practice are the main tools to bring about a change. The alcoholic must have adequate knowledge of the facts of alcoholism. He needs to recognize that it is a chronic disease and any further intake of alcohol is inadvisable and treacherous to his well-being. On the basis of this knowledge, the alcoholic must begin at once to practice thinking and acting as an abstainer. He must learn to discuss his condition when necessary, without shame or confusion, until he becomes completely at ease with this new aspect of himself. He must learn how to decline a drink gracefully, without offending or embarrassing his host, and, even more important, he must learn how to say "no" to his own inner urgings to drink. He must confront himself with his own rationalizations, whether public or private, and adopt and practice new ways of handling the tensions of every day life.

Testing

It is very common for the person who is recovering from alcoholism to wonder, after awhile, whether or not he really is an alcoholic. He begins to think that he could control his drinking now if he handled it a little differently. This line of thinking is dangerous, but understandable. Once the troubles which accumulated during his drinking career begin to subside, the alcoholic may feel that he can now drink normally. This is a failure in logical thinking, of course, because the troubles were almost always the result, or at least were greatly accentuated by, the excessive drinking.

Sometimes, it is possible for the alcoholic to drink for a month or two before he gets into real trouble again. The experiences of thousands of persons affected by alcoholism indicate that controlled drinking is impossible for them. It is only a question of time before the disease is reactivated. The desire to "test" is really an excuse to support a hidden wish to drink again and it should be recognized for what it is, a manifestation of underlying tension, which needs to be dealt with by other means than drinking.

Long Term Recovery

As in any other serious illness, the recovering patient must be prepared to carry through a long term recovery program. He should see his doctor for regular physical check-ups. He should tell his doctor that he is alcoholic so that appropriate precautions regarding the use of sedative drugs are taken. The recovering alcoholic must look after his health and ensure that his diet is satisfactory. For many years alcohol has been an important source of calories. When the alcoholic stops drinking, he must learn to eat breakfast again. Extremes of hunger and tiredness should be avoided as they lead to an onset of drinking.

Problems of Alcohol as Related to Youth

NORTH Carolina's first working conference on problems of alcohol as related to youth will be held at St. Andrews Presbyterian College at Laurinburg July 23-26.

Sponsored by the N. C. Alcoholic Rehabilitation Program, the Department of Health Education, School of Public Health, University of North Carolina, the Alcoholism Programs of North Carolina, and the N. C. State Board of Health, the conference will be underwritten by its fifth sponsor, the National Institute of Mental Health.

Approximately forty-five persons, selected on the basis of their prior knowledge in the field of alcoholism and interest in the application of educational programs centered on youth, will be invited to attend.

Teams of three people—representing local alcoholism programs, public schools and public health departments—are expected from fourteen communities in the state. The teams, to be organized into three work-groups, will work together throughout the conference under the guidance of special consultants and will be encouraged to plan specific programs to be carried out locally during the twelve months immediately after the conference.

Three work-group sessions will be held in addition to the program presented here. Time has also been alloted for individual conferences with consultants. Post-conference guidance and assistance in implementing activities planned by the participants in the work-group sessions has been pre-planned as a follow-up of the conference.

CONFERENCE PROGRAM HIGHLIGHTS

Monday, July 23, 1962

FIRST GENERAL SESSION:

Presiding—Marshall Abee

Conference Plan—Purpose—Procedure—Ralph H. Boatman, Chairman, Department of Health Education, School of Public Health, University of North Carolina

Perspective of Alcohol Education for Youth—Norbert L. Kelly, Associate Director, N. C. Alcoholic Rehabilitation Program

Tuesday, July 24, 1962

SECOND GENERAL SESSION:

Presiding: Worth Williams

Teen-age Culture—Norbert L. Kelly

Youth and Alcohol Use—George Maddox, Professor, Duke University

Research in North Carolina—Ernest Campbell, Associate Professor, UNC

DINNER MEETING:

Presiding: Carl Anderson, U. S. Public Health Service

Community Organization and Education in the Community—H. B. Walker, Associate Professor, Department of Health Education, UNC

Wednesday, July 25, 1962

THIRD GENERAL SESSION:

Presiding—William Hales

Symposium—*Forces Influencing Youth—Our Responsibilities*

Moderator: Julian Hanlon, Consultant in Mental Health

For Education: Philip Weaver, Superintendent, Greensboro Public Schools

For Public Health: Dr. Marjorie Lord, Director, Buncombe County Alcohol Program

For Religion: Jody Kellermann, Director, Charlotte Alcohol Program

For Parents: Mrs. H. S. Godwin, President, N. C. Parent-Teachers Association

Thursday, July 26, 1962

FOURTH GENERAL SESSION:

Presiding—Ralph H. Boatman

Alcohol Programs—Local, State, National—George Adams, Educational Director, N. C. Alcoholic Rehabilitation Program

LUNCHEON MEETING:

Presiding—Norbert L. Kelly

Panel Discussion: *Next Steps*—Julian Hanlon, George Maddox, Marshall Abee, Ralph H. Boatman

INDEX of INVENTORY

Bi-Monthly Journal on Alcohol and Alcoholism

May-June, 1961 through March-April, 1962

An index will be published yearly in each succeeding May-June issue.

Consult the May-June, 1961 Issue for index from May, 1951 through March-April, 1961

Currently in North Carolina there are fifteen

LOCAL PROGRAMS ON ALCOHOLISM

Educating the public is one of the major functions of these community groups and the key to prevention of alcoholism.

ASHEVILLE—

Citizens' Committee on Alcoholism
SGT. CARROL R. OWENS, CHAIRMAN
Municipal Building, Asheville

Educational Division, Board of Alcohol Control, West Wing, Parkway Office Building
DON DANCY, EDUCATIONAL DIRECTOR
Phone :ALpine 3-7567

CHAPEL HILL - HILLSBORO—

Orange County Council on Alcoholism
Box 732, Chapel Hill
MRS. MARGARET RALLINGS, EXECUTIVE SECRETARY — Phone: 942-7253

CHARLOTTE—

Charlotte Council on Alcoholism
1125 East Morehead Street
REV. JOSEPH KELLERMAN, DIRECTOR
WILLIAM HALES, ASSOCIATE DIRECTOR
Phone: FRanklin 5-5521

DURHAM—

Durham Council on Alcoholism
602 Snow Building
MRS. OLGA DAVIS, EXECUTIVE DIRECTOR — Phone: 682-5227

GOLDSBORO—

Goldsboro Program on Alcoholism
P. O. Box 1320 — Phone: 734-0541
A. T. GRIFFIN, JR.

GREENSBORO—

Greensboro Council on Alcoholism
216 W. Market St., Room 206 Irvin Arcade—Phone: 275-6471
WORTH WILLIAMS, EXECUTIVE DIRECTOR

HENDERSON—

Vance County Program on Alcoholism—Phone: GEneva 8-4714 or GEneva 8-4730
Vance County Health Center, P. O. Box 233
REV. EDWARD LAFFMAN, DIRECTOR

LAURINBURG

Scotland County Citizens Committee on Alcoholism
308 State Bank Building—P. O. Box 1229
M. L. WALTERS, EXECUTIVE SECRETARY — Phone 276-2209

NEW BERN—

Craven County Council on Alcoholism, Inc.
409½ Broad Street—P. O. Box 1466
GRAY WHEELER, EXECUTIVE SECRETARY — Phone: 637-5719

NEWTON—

Educational Division, Catawba County ABC Board
REV. R. P. SIEVING, 130 Pinehurst Lane — Phone: INgersoll 4-3400

REIDSVILLE—

Rockingham County Committee on Alcoholism
225 West Morehead Street, P. O. Box 355
MRS. ANNE WALL, EXECUTIVE SECRETARY—Phone: DIckens 9-4369

SALISBURY—

Educational Division Rowan County ABC Board, P. O. Box 114
PETER COOPER, DIRECTOR
Phone: 633-1641

SOUTHERN PINES—

Moore County Alcoholic Education Committee, P. O. Box 1098
REV. MARTIN CALDWELL, DIRECTOR
Phone: OXford 2-3171

WILMINGTON—

New Hanover County Council on Alcoholism, 316 Insurance Building
MRS. MARGARET DAVIS, EXECUTIVE SECRETARY

WINSTON-SALEM—

Alcoholism Program of Forsyth County
802 O'Hanlon Bldg., 105 W. 4th St.
MARSHALL C. ABEE, EXECUTIVE DIRECTOR — Phone: PArk 5-5359

OUT-PATIENT SERVICES

FOR

ALCOHOLICS AND THEIR FAMILIES

ARE PROVIDED BY THE FOLLOWING

MENTAL HEALTH FACILITIES

Competent Help Is Available At The Local Level

Mental Health Center of Western North Carolina, Inc.
415 City Hall
Asheville, N. C.
Phone: ALpine 4-2331

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
Chapel Hill, N. C.
Phone: 942-4131, Extension 336

Mental Health Center of Charlotte and Mecklenburg County, Inc.
1200 Blythe Blvd.
Charlotte 4, N. C.
Phone: FRanklin 5-8861

Cabarrus County Health Department
Concord, N. C.
Phone: STate 2-4121

Cumberland County Health Department
Cape Fear Valley Hospital
Fayetteville, N. C.
Phone: HUdson 4-8123

Forsyth County Program On Alcoholism
802 O'Hanlon Bldg.,
105 W. 4th St.
Winston-Salem, N. C.
Phone: PArk 5-5359

Gaston County Health Department
Gastonia, N. C.
Phone: UNiversity 4-4331

Guilford County Mental Health Center
300 East Northwood Street
Greensboro, N. C.
Phone: BRoadway 3-9426

Guilford County Mental Health Center
936 Montlieu Avenue
High Point, N. C.
Phone: 9929

Pitt County Mental Health Clinic
Pitt County Health Department
P. O. Box 584
Greenville, N. C.
Phone: PLaza 2-7151

Mental Health Center of Raleigh and Wake County, Inc.
615 Wills Forest Road
Raleigh, N. C.
Phone: TEmple 4-6484

Rowan County Mental Health Clinic
Community Building
Main and Council Streets
Salisbury, N. C.
Phone: MElrose 3-3616

Wilson County Mental Health Clinic
Encas Rural Station
Wilson, N. C.
Phone: 2-372239

Toward helping patients to re-establish satisfactory social relations, all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bi-monthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department. Please request films as far in advance as possible and state second and third choices.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Displays—primarily for local public libraries; also available to school librarians and principals. All requests should be made through local public library to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
P. O. Box 9494
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

VOL. 12, NO. 2 JULY-AUGUST, 1962

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

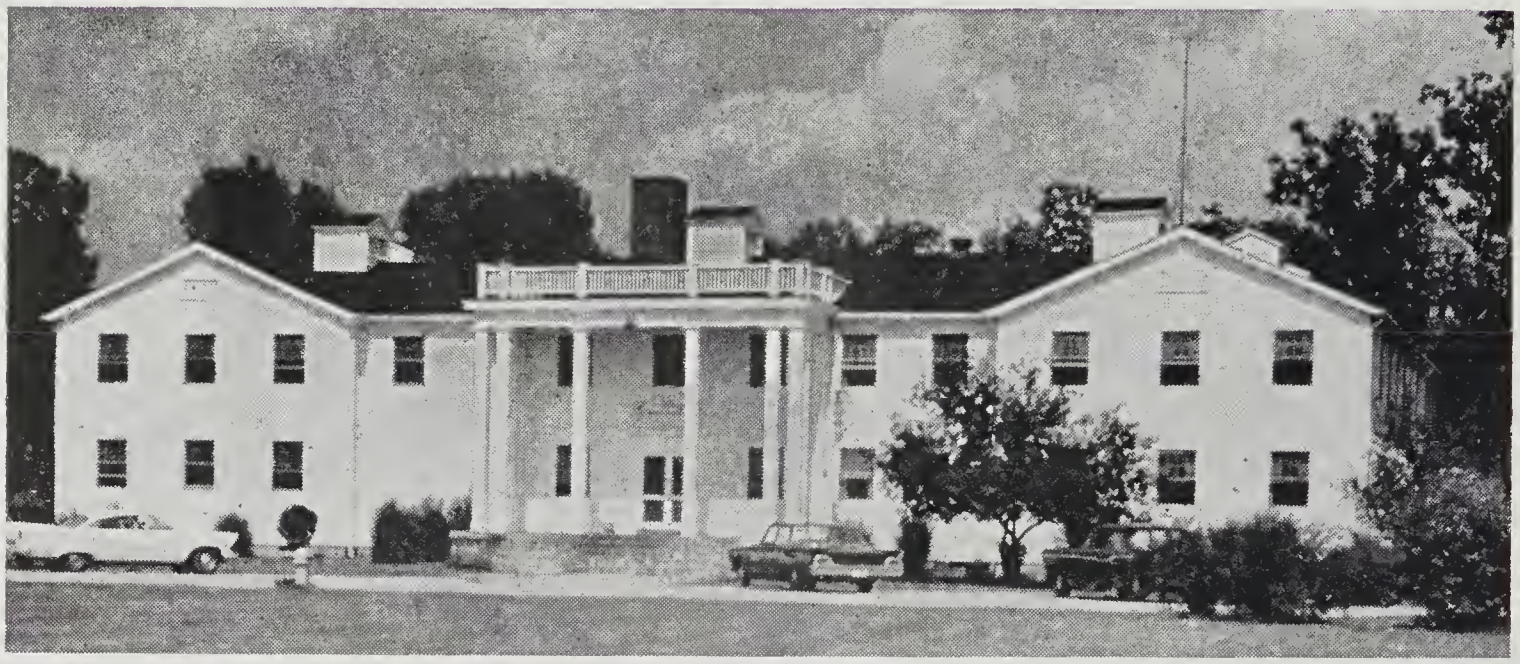
TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER



BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Medical Director, one other physician, a clinical psychologist, a psychiatric social worker, a chaplain and admitting officer, a vocational rehablilitation counselor, a recreation director-occupational therapist, and a full attendant staff.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment in response to written or telephone request to the Medical Director of the Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment. All appointments must be confirmed by mail.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Services Agency, and a complete medical history, compiled by the patient's family physician, are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M., to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
Patients must be sober upon admission, and in good physical condition. Patients may have visitors after they've been at the Center for 2 weeks. Visiting hours are from 1:00 - 4:00 P.M. on Saturday and Sunday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

NORBERT L. KELLY, Ph.D.
Associate Director

DONALD MACDONALD, M.D.
Medical Director

GEORGE H. ADAMS
Educational Director

INVENTORY

VOLUME 12 NUMBER 2

JULY-AUGUST, 1962

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices 216 N. Dawson St., Raleigh, North Carolina.

This journal is printed as a public information service. Persons desiring a place on the free mailing list must send in a written request, with the exception that *new* requests from *individuals* residing outside North Carolina can no longer be accepted. The views expressed in articles published in *Inventory* are those of the authors and not necessarily those of the NCARP. Manuscripts are invited with understanding that no fees can be paid.

Write: INVENTORY, P. O. Box 9494, Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

From The Charlotte News

People's Platform

Drunkenness Is Basic to the Problem

Charlotte, N. C. March 29, 1962

Editors, The News:

The City Council states its concern over a so-called increase in crime. Chief Hord wisely points to statistics which show no real increase and actual decrease in some areas. John Wright reports that "crime eats at the heart of the city," indicating that Charlotte is above average in murder, assault, burglary and larceny.

So far no one has faced the reality of the role played by drunkenness and alcoholism in this area. More important, no one discusses the inadequacy of our method of dealing with alcoholism and drunkenness in our police-court-prison system.

The Alcoholic Rehabilitation Division of the North Carolina State Prison Department states that over 75 percent of all persons are admitted for convictions in which excessive use of alcohol was a direct or indirect factor. Here is the admissions breakdown for the year 1961 in North Carolina:

Public Drunkenness—5,848
Drunken Driving—899
Disorderly Conduct—185
Assault—2,166

The first two categories involve arrest because the individual was intoxicated. The second two are most frequently the result of intoxication. The total for these four violations is 9,098 or more than half of the 17,996 persons admitted last year. Men admitted for nonsupport, the sole cause of which is alcoholism, numbered 1,017. An actual study was made in our state in 1960. An investigation of 100 cases turned up 100 bona fide alcoholics.

The essential fact is that one-third of all admissions to the State Prison Department result from public drunkenness alone and Charlotte leads all cities in our state in this category. Putting these men in jail does more harm than good and each admission for thirty days costs the taxpayer over $100.00.

The honorable Joseph D. Lohman, treasurer of the State of Illinois and former sheriff of Cook County (Chicago), made the following statement two years ago when addressing a convention of municipal judges: "We do not get professional criminals save they have been arrested, detained and placed in the company of men who can exchange ideas with them, as a result of which they are matured in their art of crime, and as the result of which they are confirmed in the notion that there is an area of life which will receive and entertain them, and applaud them, notwithstanding the fact that the rest of society rejects them."

A veteran Charlotte detective, speaking of the persons who commit crimes, was reported on Monday by *The News* as stating, "Most of them learn what they know in prison."

For three years I have gone to a prison unit for regular alcoholism education programs including open and frank discussions with the inmates who attend these sessions voluntarily. These men know that once they "serve time" getting a job is extremely difficult. Upon their

release, many of these men have no homes and relatives. They are welcomed by two groups only—skid row, of which jail is an institutional counterpart, and the accepting group who live outside the law. Putting alcoholics in prison with felons initiates them into the fraternity of men who live against the law. If they are imprisoned often enough their only friends become other skid row alcoholics or seasoned criminals.

Judge John M. Murtagh, chief magistrate of New York City, began an intensive study of public drunkenness in 1953. Police in New York do not arrest any person for intoxication alone but only if the person is truly disorderly. Judge Murtagh bluntly states that if the police were freed of the responsibility of trying to promote morality by dragging drunks off to jail, they would then have far more time to devote to their primary mission—that of protecting life and property.

Three years ago former City Recorder Basil Boyd requested that our office find a better way of dealing with drunkenness offenders than sending them to prison by the dozen. After adequate searching, communication, and visiting with other existing programs, a mayor's committee was appointed to work with me on this project. It included the city judge, a city councilman, a county commissioner and a Salvation Army major with years of experience in this field. This committee put together a program which the State Probation Department could not accept for lack of personnel. Several months ago I presented this same program to the city. Again things have bogged down due to legal, technical or administrative difficulties.

This type of voluntary probation and rehabilitation for alcoholics is proving very successful in other cities and is also saving thousands of dollars for the taxpayer. Our plan has been carefully examined by the present Probation Department and their wish is for Charlotte to run a pilot project which will be adopted into their regular program during 1963. The State Prison Department has urged our office to establish this program and sell it throughout the State. The associate director of the Institute of Government has carefully examined the program and declared it to be feasible and desirable.

Authority for such a program rests in the court itself. Judges can and do release drunkenness offenders to the care of individual citizens. The present plan is completely legal and in effect would provide the court with one full-time rehabilitation worker.

If the community has any genuine interest in the reduction of crime it will insist that at least one full-time person be placed in our local courts to work in alcoholism rehabilitation. More persons are arrested and placed in our city jail each year for drunkenness than all other offenses combined. To ignore this fact along with the knowledge that other communities are working successfully in this area is forfeiture of moral responsibility. The alcoholic's addiction to the bottle is surpassed only by our addiction to indifference. Our present system is nothing less than wholesale inhumanity to desperately sick and homeless men.

—JOSEPH L. KELLERMAN
Director, Charlotte Council
on Alcoholism

P.S. (July 25, 1962)

The plan of voluntary probation which the Charlotte Council on Alcoholism hopes to put into operation is based entirely upon the experience of the Municipal Courts in Washington, D. C. An alcoholic arrested and convicted for public drunkenness who indicates he wants to do some-

(Continued on page 27)

Dual Illness

I have just finished reading the article on Tuberculosis and Alcoholism by Henry T. Tesch in the May-June issue. As an arrested TB patient and alcoholic (for the past four years), I feel impelled to write you and say that your writer certainly pinpointed the important factors in this dual illness. I am co-chairman of the A. A. meeting held in the Arizona State Tuberculosis Sanitorium and intend to read the article at our next A. A. meeting.

Anonymous
Phoenix, Arizona

Origin of Skid Row

About four years ago I was stumbling around Dover Street here in Boston which is the local skid row. My serious drinking started in Bangor, Maine which claims the original skid row, Exchange Street. In the original days of lumbering in this country, there were areas that were cleared so that the logs could be dragged out on skids and piled up awaiting loading on the schooners and clipper ships which jammed the harbor of Bangor. As lumber camps were nomadic, lasting only as long as the usable timber in any given area, the saloon keepers had to be nomadic also. Consequently, his emporium consisted of a large tent, barrels of whisky and rum, a supply of usually tin cups, and his personal effects—all of which could be loaded on his wagon and moved in very short order. As a business man, the saloon keeper wanted to set up business where there was the most activity and the greatest concentration of potential customers plus the consideration of sufficient space to set up his tent. The skid row suited all his requirements admirably, and the name has stuck ever since.

Since my last drink which was in March of 1959, I have read everything I could lay my hands on in reference to alcoholism. I have run across several references to your magazine, *Inventory,* and am most desirous of being placed on your mailing list.

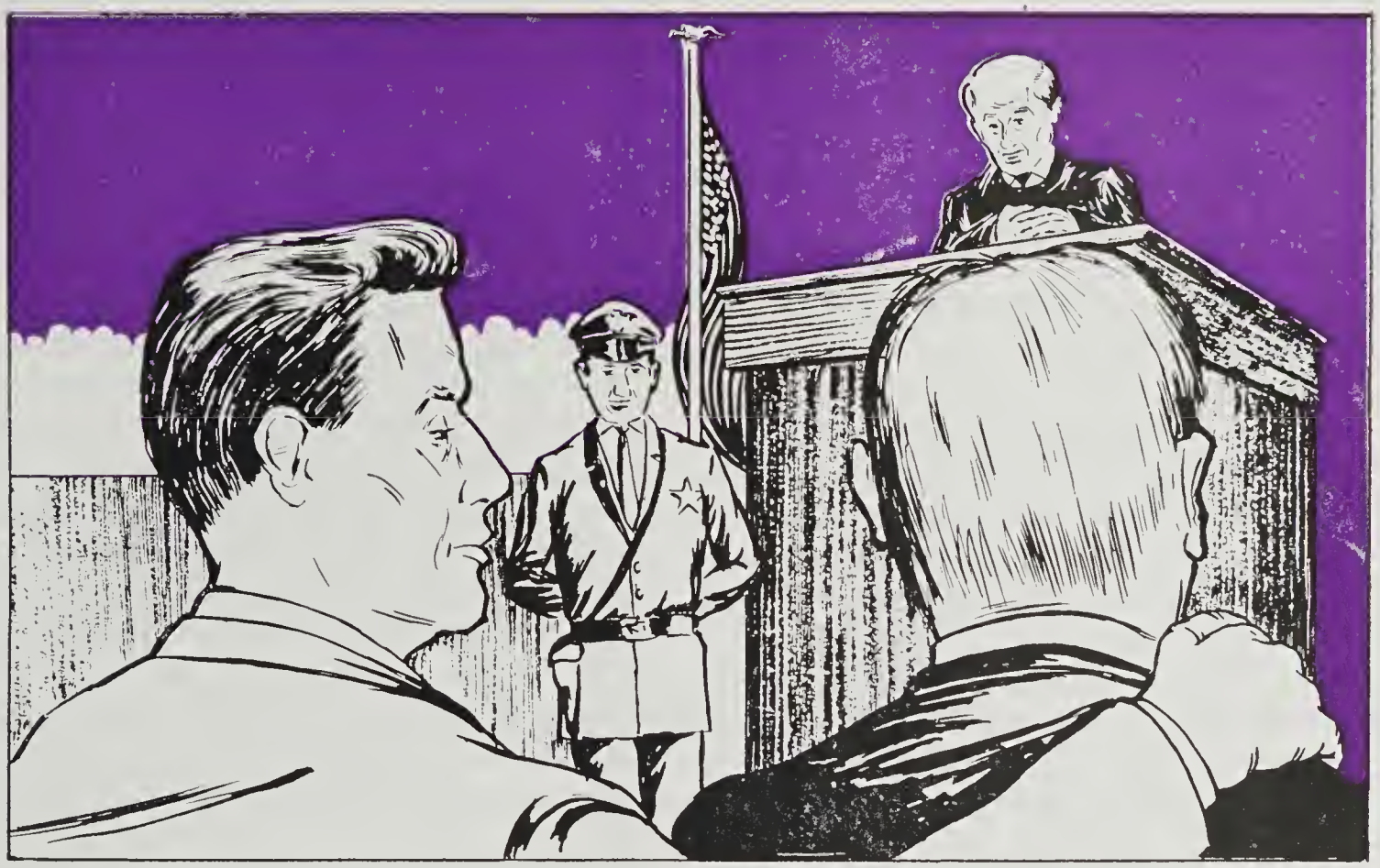
I am associated here with the New England clinic on alcoholism under Frau Doctor Brunner-Orn and the Central Service Committee of A. A.; so if I may ever be of service, don't hesitate to call on me.

Elmer E. G.
Boston, Massachusetts

Important Role

As an alcoholic who has been joyfully active in A. A. for the past few years, as a practicing barrister who sees alcoholism sometimes in the dock, sometimes at the bar, and sometimes even on the Bench, as an alcoholic husband and father who has been engaged in the perennial struggle of personal rehabilitation, I can think of few publications more informative and inspiring than *Inventory.* This publication is destined to play an important role both in the awakening of public consciousness to the scourge of alcoholism and in the enlightening of public opinion about it.

Anonymous
Arima, Trinidad, T. W. I.



A District of Columbia Court and Alcoholics Anonymous work together closely to aid alcoholics.

How a Municipal Court Helps Alcoholics

By EDWARD W. SODEN

SUPERVISOR, MUNICIPAL COURT
ALCOHOLIC REHABILITATION UNIT
PROBATION DEPARTMENT
DISTRICT OF COLUMBIA

Reprinted by permission from FEDERAL PROBATION, September, 1960. Chairman of the Committee on Prisons, Probation, and Parole was the late Commissioner David B. Karrick.

AUTHORITIES report that the disease of alcoholism is claiming 200,000 new victims throughout the Nation each year. The destruction wrought cannot be measured in dollars or cents or in human values. The United States Public Health Service ranks it only below cardiovascular diseases, cancer, and mental illness as a menace to public well-being.

Despite the fact that one-half or more of the victims of this disease can be rehabilitated—provided they can be convinced they can be helped, and provided they can be helped to recognize their condition—only a fraction of alcoholics are being reached. Only on very rare occasions does a person come to the conclusion, by himself, that he has a drinking problem and that he is an alcoholic. Just as rare is the family which does not have a drinking problem at the present time or has not had one in the past. Credited authorities claim that three persons out of 100 have a problem with alcohol.

Many years ago society punished the drunk with the ducking stool, the lash, the public cage, or stocks, and even went so far as to pour molten lead down his throat. Today these forms of punishment have been replaced by arrest and jail. Yet year after year this method has produced no results.

In 1935, Alcoholics Anonymous had its inception. As of today, hundreds of thousands of victims of alcoholism have been rehabilitated by and through the fellowship of A.A. There is hardly an alcoholic project today that does not request and receive A. A. help. Practically every community approach, every educational project, and every rehabilitation program recommends A. A. teachings, philosophy, and counsel to alcoholics. The sole purpose of A. A. is to keep its members sober and to help other alcoholics achieve sobriety. It has been said that if a program does not work with A. A., then the program has no valid treatment.

Beginning of Probation Program

Since 1946, the Municipal Court for the District of Columbia has had the help and cooperation of Alcoholics Anonymous in a program to reclaim problem drinkers. In 1939, two men called on one of the Municipal Court judges. They discussed with the judge the problem of alcoholism from personal experience and not from theory. Each admitted frankly he had a history of compulsive drinking but each was undeniably sober. The judge often has said how he was impressed with the sincerity and philosophy of his two visitors. At that time, however, the judge was seeking a remedy for a congested court docket and wanted a mass production method of dealing with persons charged with drunkenness. His two callers insisted that compulsive drunkenness was an individual problem and there was, therefore, no formula that could be applied to all.

In 1945, the judge called A. A. and two members answered. They and the assistant director of probation, now director, Robert J. Conner, Sr., discussed at length the increasing number of persons appearing in court charged with intoxication. Their meeting resulted in an experiment which was to offer A. A. to at least some of the defendants.

On December 24, 1945, the first probationer was referred to the probation department under this new experiment. That man is sober today and has attended A. A. meetings regularly ever since. The experiment was confronted with many problems, but time proved its worth and effectiveness.

Probation rules required a weekly report in person. On Saturday mornings A. A. members met with these probationers when they reported and discussed with them their problems and the opportunities offered by the A. A. program. These small informal meetings grew, and finally the group moved into a separate room in the courthouse. The size of the meetings increased and eventually a courtroom was made available for the gathering.

Basically, the meetings in the courtroom on Saturday were opened and closed informally in contrast to regular A. A. group meetings. At each meeting it was announced that the meeting was not an A. A. meeting, but simply a meeting *about* A. A. It was always stated that the meeting was not a part of probation and was an invitation for each present to affiliate with an A. A. group of the person's choice.

The court program proved its worth and in 1957 the Karrick Report, the outgrowth of a comprehensive study by a Committee on Prisons, Probation, and Parole, focus-

ed attention on facts and statistics previously unknown or, where known, had been ignored. The report also pointed to the need for expanding the then existing court program with emphasis on the success it had accomplished.

The expansion was authorized after considerable study and effort by former Municipal Court Chief Judge Leonard P. Walsh, now U. S. district court judge, and Mr. Conner. Personnel was engaged, and on September 19, 1958, the expanded program was started. It was known as the Municipal Court Alcoholic Rehabilitation Unit. Many trials and tribulations were experienced during the early days of expansion. At the beginning, men who had been arrested for intoxication and lodged in the cell block of the Municipal Court awaiting appearance before a judge, were interviewed in that cell block at 7:00 a.m. each morning in an effort to select men likely to be helped by the program. The overcrowding, noise, and turmoil, as well as the lack of proper facilities and environment for interviewing, was most disturbing and clearly indicated the need for less distracting facilities. This method was discontinued and the following system was established. Although simple, it is accomplishing its objectives.

When a defendant appears before the Municipal Court charged with intoxication, and either pleads guilty or is found guilty, one of the probation officers assigned to the Alcoholic Rehabilitation Unit presents to the judge a copy of the defendant's arrest record. The probation officer makes a quick evaluation of the defendant before the court, both from his record as well as his appearance and conduct, and if there is the slightest indication that the defendant might benefit from the program, a request is made that he be interviewed by another probation officer assigned to the Unit. When that probation officer interviews the man, he does not sit in judgment, but talks with him from the standpoint of obtaining, so far as possible, an indication as to his honesty and sincerity to come to grips with his drinking problem. If he expresses a desire to help himself and do something about his drinking, it is explained he will have to return to the District of Columbia Jail for a period of 3 to 5 days, or more if necessary, to sober up and "dry out", get cleaned up, and get himself into a mental and physical condition so that he can be helped, and can understand what will be offered him by the program proposed by the court.

After expressing an interest in helping himself, the defendant is brought back before the court, at which time the probation officer handling this phase of the program requests that his case be continued for the number of days necessary for proper "drying out."

Change for the Better

The change in these people when they return from the District Jail is almost unbelievable. Physically and mentally they are in much better condition than they would be had they been released from any other type of institution. The success of this phase of the program is due to the capable administration and understanding of Donald Clemmer, director of the Department of Corrections for the District of Columbia, and his staff.

At approximately 7:45 a.m. on Tuesdays through Fridays, one of the probation officers goes to the cell block. Those men who have been "dried out" are taken to a courtroom which has been assigned for

(Continued on page 30)

For persons who are down and out the Flynn Houses provide a home, Christian fellowship and a chance to help themselves by helping others.

The Flynn Christian Fellowship Houses

THE first Flynn Christian Fellowship House was opened in 1956 in Baltimore, Maryland. Today there are six Flynn Houses in Baltimore and many more have sprung up in various sections of the Eastern United States. Six cities in North Carolina have Flynn Houses and three others are planning to open one in the near future.

The Flynn Christian Fellowship Houses, Inc. is a non-profit, non-denominational organization offering close-knit fellowship and a rehabilitative program for homeless individuals, many of whom are alcoholics. Persons who are down and out, homeless and destitute, receive room and board, counseling, and the opportunity to find a job and establish themselves in the community.

Room and board are initially free. After the residents find employment, they are trusted to contribute $15.00 weekly toward their room and board. Since most of the support for the houses comes from these payments, the residents are not only helping themselves but are helping others to get back on their feet. Most of the Flynn Houses achieve complete self-support shortly after they begin operation.

Managers of the homes are largely recovered alcoholics and are prepared for their duties in a special training program conducted during a six-weeks' period at the Baltimore headquarters of the National Association of Flynn Houses. Besides being an administrator, the manager serves as a counselor to the residents and a friend in time of need. Cooking and other housekeeping chores are taken care of by the residents themselves.

Actually, the Flynn House is a fellowship home where a group with common problems and goals strives to accomplish together what would be difficult to accomplish individually. The warm fellowship, plus the challenge of self-help, go a long way toward renewing hope for lonely and destitute persons, and some residents choose to make a Flynn House their permanent home.

The primary purpose of the rehabilitative program of the Flynn Houses is to help the individual help himself and return to society as a useful citizen. Help for the alcoholic resident is furthered by means of group discussions, A. A. meetings and Christian devotional services. The program usually varies slightly from home to home. All meetings are voluntary and no coercion is used to compel residents to attend. From these meetings often evolve friendships which are lasting and strong as well as conducive to the continued sobriety of the alcoholic.

There are few rules that residents of Flynn Houses are required to keep. But the most important one is that no drinking is allowed in any of the homes. Residents who insist on drinking alcoholic beverages are asked to leave immediately for the protection of the many alcoholics

Flynn House, 506 Cutler Street, Raleigh, N. C.

who wish to remain sober.

Statistics have revealed that Flynn Houses are a wise community investment. In the Baltimore homes in 1960, about 1,250 persons were each given an average of about 4½ months' assistance. It is estimated that about half of these persons would have otherwise been wards of the City Jail or State Mental Hospitals. This was a saving to the taxpayers of the city and state of a minimum of $200,000. These statistics indicate that rehabilitation is far less expensive than incarceration.

Flynn Houses are Christian fellowship homes. From the moment a resident steps in the door, he is accepted without question. He belongs. He has an opportunity to help himself through helping others. He is trusted. He feels the understanding, the kindness, the firm hand of love. He has a common bond with others whose aim is one with his—to find out how to "fit" into his family life—his community—and, once again, to become a real part of the world around him. (L. W. and J. R.)

FLYNN CHRISTIAN FELLOWSHIP HOUSES IN NORTH CAROLINA

ASHEVILLE
182 Cumberland Avenue

CHARLOTTE
306 West 10th Street

DURHAM
508 Holloway Street

FAYETTEVILLE
613 Quality Road

RALEIGH
506 Cutler Street

WINSTON-SALEM
661 North Spring Street

The Derelicts of Skid Row

By JUDGE JOHN M. MURTAGH

CHIEF JUSTICE, COURT OF SPECIAL SESSIONS, NEW YORK CITY

THERE are at least half a million derelicts throughout the United States. Yes, there is a skid row in your home town, be it West Madison Street in Chicago, Mission Street in San Francisco, the Bowery in New York, the Tenderloin in Philadelphia, Congress Street in Houston, Main Street in Kansas, the freight yard on the outskirts of town, or the blighted alley up the street from the village theater.

My skid row is New York City's Bowery. For more than a century, the Bowery has been a kind of magnet for the miserable, for men and women seeking a dark place of escape. It is dotted with scores of moldering tan, red-brick, and blackened-frame flophouses, some dating back a hundred years. On its lonely beat live thousands of grimy unfortunates in almost every stage of decay.

A goodly portion of the drunks currently arrested in New York City are arraigned in night court, held since 1940 in the modern Criminal Courts Building in lower Manhattan, a little to the south and west of the Bowery, and within a stone's throw of the historic Five Points area. Court is conducted in an imposing, mahogany-walled, air-conditioned courtroom.

I remember vividly the evening I first presided in night court. Court had been in session less than half an hour when a platoon of derelicts from the Bowery, twenty in number, made their appearance. The procession was slow, solemn, and sad.

The court officer read the complaint: ". . . and that the said defendants did annoy and disturb pedestrians." He recited in detail the words that accused the defendants of disorderly conduct in violation of Section 722, Subdivision 2, of the Penal Law.

I looked at the tragic figures lined up before the bench—unshaven, drunken, dirty, down-and-out. Notwithstanding the impressive judicial setting, one was aware only of a compound of smell, noise, dirt, drunkenness, and sweating people packed into a big, but crowded, courtroom.

"You have a right to an adjournment to secure counsel or witnesses." The court officer went slowly on with the usual formula.

"How do you plead, guilty or not guilty?"

The twenty pleaded guilty, one after another.

Public drunkenness is not grounds for arrest or conviction of a crime in New York City unless it is combined with disorderly conduct.

A noted judge, John M. Murtagh served for ten years as chief magistrate of New York City before he was appointed chief justice of the Court of Special Sessions. His article was originally published in THE ATLANTIC.

Most of them were still drunk. I recognized one of the derelicts, Joe Kelly—tall, rawboned, his coarse white hair worn long and raggedly cut, his clothes filthy and tattered—as having been before me previously in district court and as having received a suspended sentence from me earlier that same week.

When I inquired facetiously if he were following me around, he hesitated, and I added, by way of explanation: "It seems you manage to get arrested when I am presiding."

At that, a mischievous smile crept over Kelly's gaunt Irish face with its week's stubble of beard and a gleam of sardonic humor flashed in his pale-blue eyes. "Sure, and you can't blame me, your Honor, if you don't get promoted," he replied.

I joined in the laughter, and then sent the twenty defendants out to be fingerprinted.

An hour later they returned to the courtroom. Several received suspended sentences. The others, who had a number of previous convictions, received fifteen or thirty days in the workhouse and went on their way to jail like a shadow parade of the hulks of sunken ships. Sunken men, gone. Their collective smell still fouled the air.

Almost of necessity I had followed the traditional sentencing policy that if a drunk is not too seedy and says he has a job, he is given a suspended sentence; otherwise, he is given fifteen or thirty days, depending on his condition. When I finished imposing the sentences, it occurred to me that most of them would be back again in a matter of days or weeks after their release.

This brought to mind Joe Kelly. But Kelly was gone. He had not returned from the fingerprint room with the other nineteen derelicts. Consternation reigned.

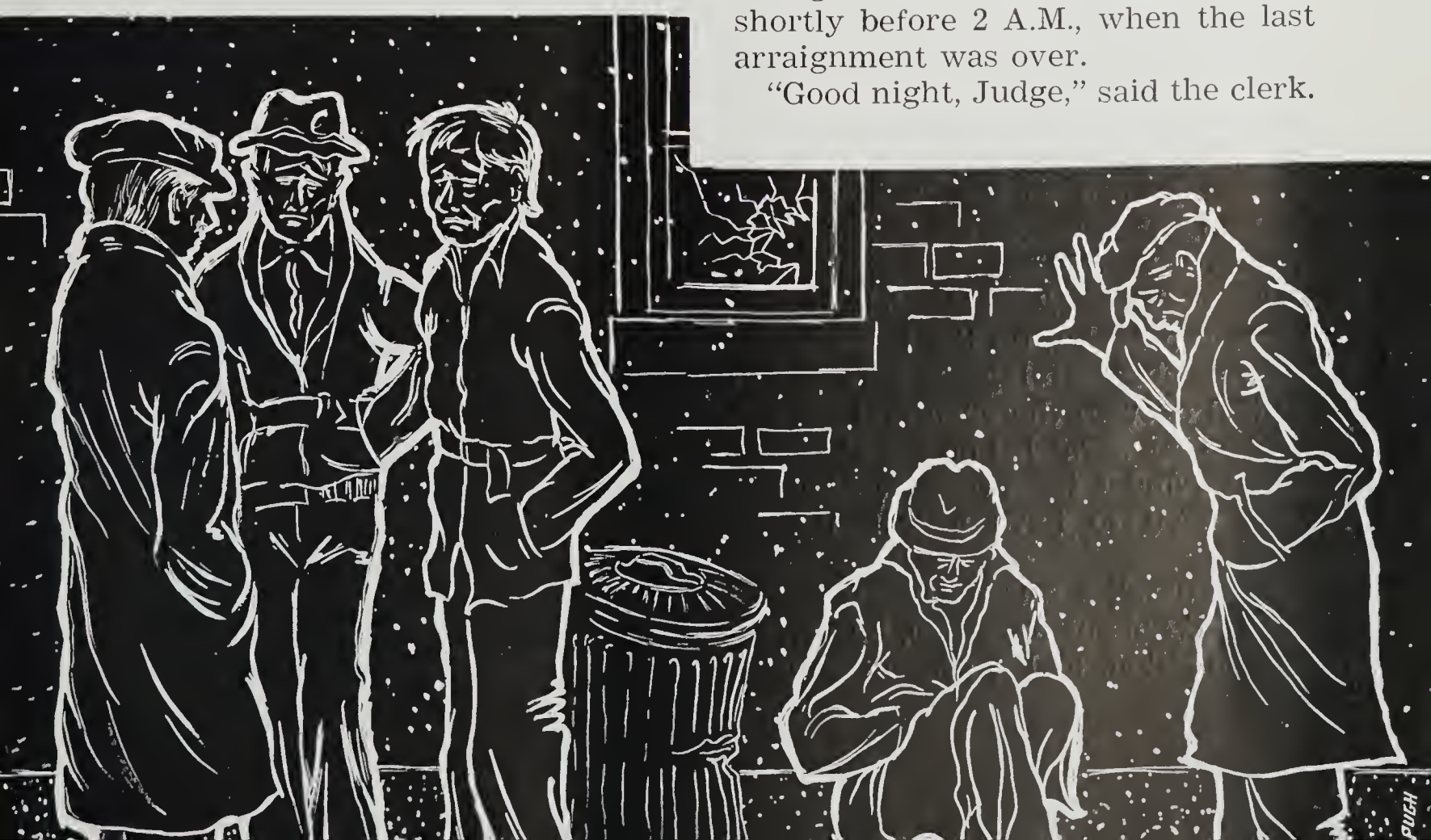
"Relax," I said to the court staff. "Sentence suspended."

The suspension of Kelly's sentence for a second time within a week, this time *in absentia,* dispelled the panic and spared the arresting officers, Roy Nelson and Bob McCoy, the necessity of accounting to their superiors for the escape of a prisoner.

"Next case!" called the clerk. "Officer Riley and ten peddlers."

Night court was itself again. One arraignment followed another until shortly before 2 A.M., when the last arraignment was over.

"Good night, Judge," said the clerk.



"Good night," I responded as I proceeded into chambers with the court officer.

And there on a sofa was Joe Kelly in a deep sleep of peace.

"Don't disturb him; let him sleep," I whispered as I donned my coat and departed.

Night court is truly the dismal dumping ground for the also-rans of society. The faces that had stood before the bench that night haunted me in the days that followed. Not fully appreciating the enigmatic nature of the problem, I vowed, somewhat naively, not only to do something about it but to do it quickly.

Nelson and McCoy, the arresting officers, were known to the Bowery habitues as "ragpickers." Their daily assignment was the rounding up of derelicts along the Bowery from Chatham Square to Cooper Square, the most miserable mile in the United States. A tour of duty with them a week later made more vivid the tragic picture I had witnessed in night court.

Nelson was a tall, lean man in his fifties, with closely cropped brown hair, a sallow face, and amiable brown eyes. He wore a gray suit on the job and was always chewing gum. McCoy, a small, stocky man in his forties, was the pugilist of the pair. They worked from a patrol wagon known as the "pie wagon." Nelson, the more gregarious, did most of the talking.

"There's one," said Nelson. We were proceeding up the Bowery and approaching Rivington Street. We pulled over to the curb and parked. A man lay sprawled on the sidewalk. Nelson and I went over to him. McCoy went to have a look up the street.

The derelict was a huge man. He was only about forty-two, but grime, malnutrition, and a graying stubble on his sunken cheeks made him look much older. An unlabeled pint bottle containing a pinkish fluid lay at his side. He had no socks, and his bare feet protruded through holes in the soles of his shoes, his big toes sticking out of the uppers. A zephyr of alcohol confirmed an already obvious diagnosis.

"Well," Nelson said, "darned if it isn't Andy. He's been around for years. Let's go for a ride, fella." He pointed to the man's hands. "See the pink stains between the fingers? Canned heat."

McCoy returned, and Andy tottered wearily into the wagon. With that we resumed our tour, and before we reached Stanton Street, Nelson pointed out the Salvation Army shelter. "That's the 'Sally,'", he said. "The Army is truly dedicated; they run a clean flop. But it's not cheap—most of the guys pay seventy-five cents or a buck."

In front of the Sally was a line of sodden unfortunates waiting patiently and silently on the street. "They're waiting for the gates to open next door at the Bowery Mission," said Nelson. "No grub and no flop unless you first listen to the preacher," he observed. "The mess line winds through the chapel."

At Third Street we turned east, and in a doorway just off the Bowery sat two drunks surrounded by cans of refuse. An empty bottle lay on the sidewalk in front of them. Nelson and McCoy roused them, loaded them in the wagon, and drove off. They, too, were well known to the police.

Down the street we passed the "Muni."

"Anyone can get a warm flop and some grub here," said Nelson.

The "Muni" is the Men's Shelter conducted by the city's Department of Welfare. Formerly a Y.M.C.A. residence, the Muni is the hub of Bowery life. In the winter several

thousand stand in line for chow. Some six hundred are given lodging; several thousand are sent to commercial flophouses with a ticket for a night's bed, courtesy of the city.

"Drunk or sober, any time of the day or night, a guy is welcome at the Muni," mused Nelson.

When the pie wagon was full, we proceeded back down the Bowery into Chinatown and to the Elizabeth Street station house.

As I prepared to leave, Nelson made a parting observation: "These bums are endless," he said. "Arrest fifty tonight, and you'll find fifty more tomorrow night. And the next night. And the next. Sometimes I think we ought just to drop them at the Muni, rather than bother you judges."

Attempt to Understand

Since that time, I have tried to fathom the enigma that is the Bowery mile of misery. I have visited social agencies and missions in and near the Bowery. I have made the acquaintance of many of those whose lives are dedicated to helping the unfortunate. I have become fascinated by Alcoholics Anonymous, which has helped many whose problem is primarily alcoholism. I have been inspired by the spiritual zeal of men such as the Right Reverend Monsignor Charles B. Brennan, who conducts the Holy Name Center for Homeless Men on Bleecker Street. I have become acquainted with the personnel of the Department of Welfare, who operate the Muni and who conduct Camp La Guardia in Orange County, a rest home for the aged and infirm. I have come to realize that, as inadequate as the city's program may be, it is properly regarded by the experts as "probably the most highly developed community program for the care of the homeless" in the United States.

I have attended the Summer School of Alcohol Studies of Yale University (I now boast I got my law at Harvard, my alcohol at Yale). I collaborated with the commissioner of welfare in the establishment of a rehabilitation center at Hart Island and had my colleagues suspend sentence on all who volunteered to go to the center. I also created a special court known as the Homeless Men's Court to make the entire proceeding more humane.

The problem is almost as old as the city itself. In the early 1800s, when Broadway and Chambers Street marked the outskirts of town and Times Square was a wilderness, members of the City Watch (New York City did not yet have a police department) spent virtually all of their time rounding up derelicts in the Five Points area of the old Sixth Ward.

In 1845 a police department was created, primarily to deal with Bowery derelicts. Originally an amusement center, the Bowery had declined and by this time was well on its way to becoming the city's skid row. In the first ten years of the department, the number of drunk arrests totaled more than 100,000. By the 1870s the number exceeded 40,000 a year; one out of every three of the derelicts arrested was a woman; children as young as eleven years of age were arrested; the usual penalty was ten dollars or ten days in jail.

In his memorable vice crusade of the early 1890s, the fabulous reformer, the Reverend Dr. Charles H. Parkhurst, called upon the police to make even more drunk arrests. He was shocked by the widespread inebriety that prevailed in the Bowery. One evening in 1892 he gained admittance to a flophouse and beheld dozens of drunks asleep on bare canvas cots, breathing heavily in the foul air. He put his handerchief to

his nose and exclaimed: "My God! To think that people with souls live like this!"

Since the turn of the century, there has been an increasingly tolerant attitude toward the Bowery derelict, but from time to time the conscientious—some in wicked triumph, some in honest pity, some because they recognize a community responsibility—call upon the city fathers to clean up the Bowery. More arrests follow for a week or two.

In the fall of 1935, during one of these periodic drives, a group of derelicts was brought into night court, then located in an old courthouse on West Fifty-fourth Street. They were charged with public intoxication. Many of them were still drunk. They were defeated men. They had no desire to fight constituted authority. One after another, they pleaded guilty. Then the court officer called the next case.

The charge was read: ". . . and that the said defendant did then and there commit the offense of . . ." The court officer rolled out the words that accused the defendant of public intoxication because he had been lying on the sidewalk while under the influence of liquor.

"How do you plead, guilty or not guilty?" The court officer's final question was quiet, but insistent.

The defendant remained silent; his eyes seemed to be reflecting on something lying at his feet.

Magistrate Frank Oliver scrutinized him. He was long unshaven, dirty beyond belief, clad literally in rags, but younger than the others. He would not take his eyes off the floor.

"Look at me," the judge said.

"Yes, your Honor." He spoke with a refinement of accent that startled even the court officer. His brown eyes were gentle and questioning as he looked up. Then he seemed to find confidence somewhere, and he smiled as though the judge and he shared a little deprecatory joke. Only then, in the wrinkles of his smile, could it be seen how fully caked and black was the dirt that matched his beard.

"How do you plead to this charge, guilty or not guilty? the judge asked.

"Not guilty, your Honor," he answered slowly and almost in a whisper, as though he were talking to himself.

Then, his confidence again returning, he revealed himself as Louis Schleicher, a once promising assistant district attorney, and he moved to dismiss the complaint as being insufficient on its face. To the obvious delight of the whole crowded courtroom, the judge granted the motion. He ruled that the police must allege and prove not only that the defendant was drunk in public, but that he was disorderly, that his conduct caused or tended to cause a breach of the peace.

And who, indeed, is less disorderly than a Bowery derelict? He sleeps on the sidewalk or in a doorway. In repose, he looks to be in his fifties. The mouth hangs open, and some of the upper teeth are missing. His face is streaked with clotted blood from a gash on his forehead. He wears work shoes without socks, and khaki trousers. A big safety pin holds his ancient brown coat together at the neck. His clothes are dirty and much slept in. The skin is gray, the lips are brown. The eyes are squinted shut, perhaps against the cold morning light, perhaps against a dream. He is part of the street scene. He disturbs no one. Visitors who stroll in the Bowery expect to see him.

It was not long after Louis Schleicher's brief moment of glory that Chief Magistrate Henry H. Curran directed that all forms of complaint and commitment dealing with the charge of public intoxication be forwarded to judicial headquarters.

He then had the forms destroyed. He was seeking thereby to implement Judge Oliver's decision and to preclude the police from thereafter invoking the statute against public intoxication, confining the arrest of derelicts to instances in which they are at least allegedly guilty of disorderly conduct. As a result, the public-intoxication statute has never since been used in New York City, and drunk arrests made under the disorderly-conduct statute constitute only 3 percent of the total arrests.

This is what Police Chief William H. Parker of Los Angeles had in mind when, in arguing against a proposed reduction in the annual budget of his department for the year 1959, he suggested wryly that perhaps the department should abandon its policy of harassing drunks in favor of the "New York system, where drunks are left to die in the gutter."

Los Angeles each year has nearly 100,000 public-intoxication arrests, in marked contrast with New York City, where no such arrests are made. In New York, arrests of skid-row derelicts are limited to instances in which the drunk is at least allegedly disorderly or dangerous and these amount to fewer than 15,000 a year.

Chief Parker implied that the policy of not harassing derelicts is peculiar to New York City. He is right. Night after night in other cities, the police pick up drunks on the streets—filthy, battered, sick, unutterly pathetic—and lock them up in the "drunk tank." In the morning they are released or sentenced to a short term in jail, only to be picked up again soon after their release. Virtually all of these chronic drunks are recidivists. Many of them have been arrested several hundred times. Approximately one million arrests annually—almost half the criminal arrests in states throughout the country—are so-called public-intoxication arrests. More than half of the population of county jails throughout the United States is comprised of persons committed for public intoxication.

Why do cities other than New York persist in an inhumane and un-Christian approach to the skid-row derelict? Can we properly bear malice in our hearts for the poorest among us—empty, bewildered souls, born in the image of God—whose degradation our society and our culture helped create?

Incarceration Not Answer

Incarceration never cured a derelict, never did and never will. The problem of the skid-row derelict is basically social, medical, and spiritual in nature. Whether the derelict is a true alcoholic or merely a problem drinker, he usually has a much more deep-seated pathology, an emotional disturbance, if you will, that is an enigma to all of the disciplines. The penal approach to his problem is but a feeble attempt to repair damage done in early childhood.

Why, then, do judges go right on sentencing men and women through an endlessly revolving door? Don't they know the folly and futility of it all? Of course they do. But they say, "This is what the public wants. It wants these bums punished."

But why? What drives people toward the urge for punishment? Ask them, if you will. Tell them how useless jails have been historically when it comes to reforming derelicts. And they will ask you, "How can you let such men go unpunished?" You might ask, "Are they hurting you? Are you being threatened? When they overindulge, who are the losers, except themselves?" After you have made your most persuasive arguments, they will look you in the eye and reply, "It's justice."

(Continued on page 23)

Some Spiritual Aspects of Alcoholism as related to the Flynn Christian Fellowship House

By the Reverend Joseph L. Kellermann

By rejecting, stigmatizing, condemning and punishing, society commits a greater sin against the alcoholic than his drunkenness is against society.

This article was originally given as an address at the annual conference of the National Association of Flynn Christian Fellowship Houses, Inc. held in Capon Springs, West Virginia, May 15-17, 1962. It appears in Inventory by permission of the author.

THERE is no universally accepted definition of alcoholism but there are many realistic descriptions of this illness. One of the more colorful descriptions is that it is a religion of transcendence of all earthly problems by the use of anesthesia. For the time being only the user achieves a mental and emotional condition that lifts him above all problems of life which are **now** soluble in alcohol but are crystallized in guilt and remorse with the return of sobriety.

A fundamental characteristic of the emotional aspect of persons who are not able to achieve the discipline of maturity in human life is an attitude of Omnipotence. Dr. Ruth Fox lists this neurosis as one of the basic problems of the alcoholic. It is not peculiar to the alcoholic alone, but the inhibitions are so completely released by alcohol that this aspect of personality becomes enormous in the behavioristic consequences of drinking. In the area of religion this characteristic is called Pride, the first of the seven mortal sins in classical Christianity. Its opposite in virtues is Humility, which becomes the focal point of mental and emotional recovery from alcoholism.

The nature of the problem of recovery from alcoholism is a surrender of pride and the acquisition of humility. This is not accomplished by the process of reason but comes as a result of experience and the impact of reality, both divine and human.

The first three steps of Alcoholics Anonymous are in perfect harmony with this idea: "Admitted we were powerless . . .; Came to believe . . .; Turned our life over to God . . ." In sequence this is the acceptance of humility, an act of faith and seeking help.

This same principal is proclaimed by Dr. Harry Tiebout who states that the events in recovery are as follows: First, there must be a shocking experience which is so painful that it results in deflation of egotism in depth. If, at this point, the alcoholic, as an act of faith and trust, acquires humility and seeks and finds help, then recovery begins and therapy is in effect.

This principle is in harmony with what is called the "theology of crisis" and may be termed a psychological description of conversion. Original sin occurred when man acquired mind. Partaking of the fruit of the tree of the knowledge of good and evil, Adam exercised his volition by doing that which was right in his own eyes. This is a basic reality for all mankind. Immaturity is always marked by a degree of omnipotence and is abandoned through the painful process of growing up. For some this is a slow, gradual process. Others postpone growth until it is painfully thrust upon them by the circumstances of life.

Humility cannot occur in the alcoholic until it is practiced in principal by those who deal with him. This is one of the fuller meanings of the Twelfth Step in A. A. Having had a spiritual awakening, beginning in step one with humility, the principles are practiced in all their affairs. If we are dealing with alcoholics, our own area of

JOSEPH L. KELLERMANN, an ordained priest of the Episcopal Church, came to Charlotte in 1950 to serve as rector of The Church of the Holy Comforter. A 1953 graduate and past faculty member (1958-59) of the former Yale Summer School of Alcohol Studies, he helped to organize the Charlotte Council on Alcoholism and became the executive director—in which capacity he still serves—of its Alcoholism Information Center in 1958. Mr. Kellermann was instrumental in getting Charlotte's Flynn Christian Fellowship House established in 1961 and is a member of its board and the board of the National Association of Flynn Houses. His other active community interests have included the Traveler's Aid Society and the Florence Crittenton Home. He is also a past president of the local mental health society and a past chairman of the board of directors of the Charlotte Mental Health Clinic.

spiritual recovery may be a prelude and a postlude to the recovery of the alcoholic, but we must never feel for one minute that we are effecting his recovery. It is of the utmost importance to understand that recovery is that which happens between God and the alcoholic. We may remove ourselves as handicaps and barriers to this event and we may provide individual and group support after it has occurred, but at the heart of the matter there is an encounter between God and man. In this most intimate experience of life, no man has a right to intervene or participate. Also, unless one is willing to assume the full moral responsibility of the failure of the alcoholic, one cannot assume any credit in the process of recovery. God acts when the time is ripe.

The pain of the consequences of drinking must become more powerful than the pleasure of alcoholic escape before the alcoholic is ready to stop drinking. In this area we do have a real measure of responsibility in helping motivate the desire to stop drinking. We have no right to abort the consequences and mistakes of others. If we remove consequence, we postpone the arrival of the condition in which the person will admit he is powerless. Also, when the painful consequence catches up, we must be willing to allow the pain to last long enough to be effective. Compassion is suffering with a person or bearing with a person, not suffering ourselves in the removal of the suffering of others. All too often the corrective hand of God is thwarted by persons who decide what is best for the alcoholic and remove the consequences of drinking.

The preservation of omnipotence is achieved by the alcoholic if he can successfully manipulate us to do his bidding. In this area our lack of faith is all too evident. We fail to believe that there is a degree of order in the universe and that God knows a little more about this than we do. Lacking faith and being unwilling to run the risk which faith always entails, our own anxiety for the alcoholic forces us to rush in and save the immediate crisis but, in so doing, to injure the over-all condition. The reverse side of this is the attempt to force the alcoholic to do what he should and thereby create rebellion. Whatever we gain by forced compliance from the alcoholic

will be lost when the first drinking opportunity arises. God does not force anyone to turn to him and we have no right to attempt improvement on this method. The alcoholic exercises the principle of rebellion against coercion and force. This is natural, instinctive and is not immoral. To attempt to force compliance is to prolong the battle. To acquire and maintain neutrality in this area is an act of spiritual genius.

The crux of recovery is the acquisition of humility but not humiliation which is a counterfeit of humility and valueless. Humiliation results in embarrassment, shame, guilt and an intense desire to escape. It leads to additional drinking where family and friends rush in to save the embarrassment. In reality they are meeting their own emotional need rather than having enough mature courage to allow the problem to resolve itself. On the other hand there are those who wish to embarrass and humiliate the alcoholic. The social acceptance of arrest and imprisonment is a clear example of this.

Humiliation may be described as a detour around reality in a desperate attempt to get back on the main road of pride. Humility is the facing of reality with the courage to cut a new path right through life's most difficult problems. If the alcoholic does not attain humility, it may be due to the fact that family and friends are humiliated and embarrassed by their own pride. Seeking, then, to rejoin his peer group, the alcoholic is thus led back to pride, not to humility.

Humility may defy us when acquired by the alcoholic for it removes the subservience of the individual and nullifies the need for an escape road from embarrassment. Humility is the process of restoration which includes God's forgiveness and self-forgiveness. Once acquired, it does not allow its possessor to grovel, be pushed around, or to be exploited. Once acquired, the need for the fellowship of equality is essential and the alcoholic can no longer be treated as an outcast or inferior person. Therefore, the preparation for this new birth in humility, and the follow-up after it occurs, requires humility on the part of those who work with the alcoholic; otherwise recovery places the alcoholic in immediate conflict with those attempting to help.

The philosophy of the Flynn Houses should be examined in the light of these principles as contrasted with the ethics of society and its treatment of the alcoholic.

Home For the Homeless

The Flynn Christian Fellowship House is a home for homeless persons where strangers are accepted, fed and clothed as members of a family. But it is not a temporary home where one may escape the pain of one's action. It is not, for instance, a plush dog house for an alcoholic husband who has just left his family which has given him the choice of living with the bottle and his illness or with them. It would be immoral on our part to allow a man to escape the responsibility of his immediate existing family. A husband in the dog house is not a homeless person. He is not in prison, hungry, thirsty, naked or a stranger.

However, this principle does not exclude persons who still have a family with whom they may be reunited. Some persons who have had no association with a family for months or years because of chronic alcoholism have been able to maintain long-term sobriety in a Flynn House, regain self-support and have returned to their families. This, too, must be a matter of their own choice. Sometimes the former partner has

remarried. There are instances when an attempt to make restitution or effect reconciliation could injure self and others which is a fact recognized in step nine of A. A.

A large percentage of persons who come initially to the Flynn Houses may never have had a home of their own. Many arrive at our doors having experienced nothing except jails, jungles, flop houses and fleabags for a period of years. Their recovery includes acceptance by a peer group with whom they can live without the bottle. The Flynn House provides this and reverses treatment the person has received for years.

Society's Attitude

Corporate guilt with limited liability is standard procedure of society in dealing with the alcoholic. Society, by rejecting and stigmatizing the alcoholic—scolding, punishing and condemning—commits a greater sin against the alcoholic than his drunkenness. Recovery is based then upon a reversal of society's treatment which has apparently been "bad medicine" since it results in increased illness, not recovery.

Society's treatment of the homeless alcoholic is as follows: When intoxicated, he is arrested, jailed, judged and often imprisoned for months or even years. This treatment, which is supposed to prevent a repetition of drunkenness, in reality increases the need to drink. Society has acted like a scolding mother who takes over when the son is drunk, sobers him up, condemns him for his drinking, provides food, shelter and clothing for a while, and then puts him out on his own again. As one chronic alcoholic put it, "I knew I could get food and shelter in jail if I could not get it anywhere else."

Come in when sober and get out when you drink is an involute principle of the Flynn House. A man is received when homeless, jobless, broke, hungry, yet for this same man there is no food, shelter or protection when he is drinking. If, however, he returns sober after a drinking bout, he is accepted without scolding, judgement or condemnation. In our present culture this acceptance is similar to the dynamic of A. A. when a man returns after a slip.

It is not that groups other than recovered homeless alcoholics could not do this, but simply that other groups in our society do not do this. One trip to prison and four out of five jobs are immediately withdrawn from possible employment. Society, which spent enormous sums of money to arrest, try and imprison the man, now will spend nothing to provide food, shelter, clothing and jobs to enable this person to receive the benefits of his just completed "corrective" treatment.

The Flynn House provides a genuine area of choice for the homeless alcoholic. He can return to his bottle gang who will share their last drink with him, or turn to the Flynn House where his peer group will share their last loaf of bread with him. Society tells the homeless-alcoholic it will feed, clothe, shelter and work him if he drinks. The Flynn House states it will feed, shelter and clothe him if he is sober and thus enable him to work as a free man in dignity.

Society exploits skid row and allows exploitation of it. Society may try to eliminate skid row by physical destruction but if one large skid row area is bulldozed under, two smaller skid rows appear in the same city. Skid row is a social illness—not a real estate problem.

A large dwelling can become a skid row flop house or a Flynn Christian Fellowship House. The sole determining factor is the purpose for which it exists and the attitude of those

who control it. The Flynn House becomes an island of sanity in an insane society, a simple segment of society into which a homeless person can move and discover an absence of exploitation. Society has exploited the homeless alcoholic by giving him the least possible rental value for the highest possible price. It exploits the alcoholic by cut-rate wages for spot labor or menial tasks for which there is substandard pay.

Police are supposedly protecting society from these persons when they are drinking, but in effect these persons should be protected by police from persons who exploit them, drunk or sober. They are robbed, beaten, rolled by others on skid row and they are robbed of their dignity by arrest, beaten by the condemnation of society in our courts, and rolled of any available cash by fines levied against their illness. By contrast, society expects police protection for "parties" at country clubs, fraternal orders, etc.

Contradicting Laws

In most communities the laws which govern the treatment of the homeless alcholic are in complete contradiction to "The Law" which has divine origin.

Religious groups have used the homeless alcoholic for too long as a symbol of disgrace and sin, guised as an example of the evils of drink. This person becomes a wonderful football to be kicked about when the minister runs out of a fit subject for a sermon, so he has a fit about the drunkards. We must also realize that the homeless male, alcoholic or otherwise, has been the object of religious aggression and arrogance. The vast majority of those who try to convert him are expressing their own hostility and bitterness toward him. Not infrequently the attack reveals the many faces of envy of those sadly mistaken persons who think the homeless alcoholic lives a life of ease and revels in the happiness of repeated drinking bouts. If a homeless alcoholic recovers his spiritual sanity, it is despite this conglomerate attack and condemnation, not because of it.

Most efforts in the name of religion perpetuate the condition by devaluating the alcoholic as a person, project hostility and condemnation, and attempt to coerce through fear what can be accomplished only through forgiveness and humility. Salvation comes from the Latin "salvus" which means to be healed or made whole. The word whole and holy evolve from the same source and mean literally the same thing. Neither can exist without the condition of the other for they are like two sides of the same coin. Saving by healing is just as valid as healing by saving. Today there is a tremendous overemphasis on the latter and in the area of alcoholism an almost complete neglect of the former.

There are far too many store front predatory gospelers who tend to count noses at services and measure their success by the number of decisions. If a man must be preached to and prayed over before he can get the essentials of food and shelter, he will accept preaching and praying, and will even pray with you to gain this end. However, there is little likelihood that this will result in permanent sobriety.

God finds man. Man does not seek and find God, nor is it possible for a person to give religion to another. Religion may be described as our response to God's search. In dealing with the homeless alcoholic, it is not our primary task to try to insure the fact that man will find God for this is the reverse of the way it works. Our primary area of responsibility is that we attempt to reveal

the love and the will of God in our own lives which necessitates the greater degree of humility. This cannot be done as righteous to the unrighteous, but from one who has been forgiven much to one who stands in need of much forgiveness. If we have been found, this knowledge of God's presence within us is manifest in our own security. Fanaticism is created by deep uncertainties and fear of the insecurity of one's own position. The fanatic tries to force another into accepting his own position in order to prove that he is right and thereby prove his belief. The fanatic cannot tolerate a dissenter or one who would do it another way.

Philosophy of Flynn Houses

The Flynn House accepts, feeds, clothes, visits in prison without first trying to convert. As an act of faith we leave to God the task of conversion and try to fulfill our religious duty by the expression of His love and the fulfillment of His will. As a criterion of this, we take literally the parable of the final judgement—"I was hungry and you gave me food, I was thirsty and you gave me drink, I was a stranger and ye welcomed me, I was naked and you clothed me, I was sick and you visited me, I was in prison and you came to me."

The parable does not deal with preaching and praying but leaves the clear division between the faithful and the unfaithful in the fulfillment of the basic needs of other human beings. This is why I believe that the Flynn House cook who gets up before daylight to prepare and serve warm breakfasts to men going out to work is an extension of the Lord's Supper into the reality of life. I am a priest of the Episcopal Church. A priest of the English Church stated that when bread is placed on the Holy Table and blessed, then all bread becomes holy, including that which is made at the bakery. When I bless and break bread at God's table, I do sacramentally what the cook does in reality in his kitchen. He is not trained and set apart to serve at the altar and I am not trained or qualified to fulfill his role in the kitchen. What I do professionally as an ordained priest, he does as a layman in the priesthood of all believers and there is no essential difference in the quality of the meaning of our acts.

It is not a question of whether one comes before the other—it is a requirement that both do exist in reality. Each done in His name and because of His love give meaning and support to the other. In our present society, it is far more likely that food shared in love with the homeless will lead one to church rather than our formal religious worship leading to the sharing of food with the homeless.

Two great parables in the New Testament give us guidance in the spiritual aspect of alcoholism or any other human problem. The story of the Prodigal Son and the Good Samaritan are known to all persons who have any knowledge of the New Testament. If we keep these parables in mind, we will not be caught out of line in our dealing with alcoholics.

The father of the Prodigal gave one of his two sons half of all that he possessed and let him throw it all away. Having spent all, the son was reduced to the extremely distasteful task of keeping swine. His plight became so acute that he would have eaten husks fed to the pigs. The father made no effort to rescue him. In fact, the key phrase in the parable is "And no man give unto him." This is followed by "And when he came to himself." In that moment of despair, the son accepted reality, chose to be

humble, and returned in this condition. The father who had the courage to allow his son complete freedom to fail utterly without condemnation or interference now goes out to meet the son, extending forgiveness and restoration to family membership. The father risked the complete loss of his son, but regained his son completely. Parents and society rarely allow the alcoholic to fail in dignity and without interference or condemnation and, therefore, few come back in humility as did the prodigal. We cannot save the alcoholic from the choice he makes and if we have the courage to allow the failure, we have the ability to forgive also.

The Good Samaritan, the other parable, was given as an answer to the question "Who is my neighbor?" The object of the story is a man, beaten, robbed, and half-dead. The subject in the story is a priest and a lawyer who walk away from this person and a Samaritan who administered the needed care.

The Samaritan's Teaching

Translated into the present-day setting, the minister passes by and preaches against the homeless alcoholic. The lawyer passes on the other side and prosecutes in court if the man is arrested. The Samaritan was considered an inferior person by the priest and Levite, and today those who help the homeless alcoholic are sometimes placed in this same category. It is not necessary to have prestige and professional status to show mercy. The Samaritan teaches us that the time and the place and the condition of administering mercy is where the man is at the moment of need. If we minister in God's name and with compassion, we may become agents of God's healing and therefore aid the condition that leads to the inner change of healing which we call holiness.

The most difficult task is to exercise discipline within love or to love while exercising discipline, but love cannot exist without it. A homeless alcoholic has been so deeply injured by life and so exploited that he finds trust and gratitude very unnatural reactions. He may come to the Flynn House looking for something for nothing. This he gets in reality. Shelter, food, clothing and love are given freely. It is the discovery of the sincerity of those who receive him and the realization that he is not being exploited that allows the homeless man to find a genuine home in which there is no conflict between justice, discipline, and compassion.

Love and Acceptance

It is the removal of ourselves from the world's standards and the creation of a small island of sanity and love within this outer world that attracts the homeless person. It is not that we do for him, it is that we create a climate and condition in which he can accept himself because he is not on the defensive against our condemnation. He can accept help initially because it is from peers, and he understands the moment he is helped that he may extend this same help to others.

Ultimately it is our faith in God's plan and trust in His way that determines our own success or failure in dealing with these people. We do not have to pray or preach, scold or condemn, admonish or coerce to achieve our goal. It is our task to reveal the love of God through our affection, and the will of God through the discipline of humility. We can do no more, for the dignity of that inner change must be left to the decision of the man and the Grace of God. This is the heart of the spiritual problem of alcoholism.

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But the obligation of a judge of a criminal court is to dispense mercy as well as to administer justice.

Psychiatrists who have studied the motivations of the urge to punish say this talk of impersonal justice is more often than not an outlet for people's repressed aggressiveness. It is never he who is without sin who casts the first stone. Is it not likely that people cast their own sins, their own miseries, guilts, and hatreds along with the stones they throw? This not to say that the derelict, abandoning all that is sacred and leading a life of utter degradation, is attractive or nice. But what right do the rest of us have to become so furious with him? Those who wish to see him treated as a menace to society ought to look into their souls and gauge their reasons.

So should the law. It is time to put the hostile public in its proper place and to stop dignifying its thirst for vengeance and instinct for hate. It is time the police and the judiciary, instead of following in the wake of a misguided public, assumed the responsibility of providing leadership toward understanding. Saint Thomas Aquinas, one of the world's greatest intellects, stated that the human law was limited to violations of the moral law that affected the common good. He taught that personal sanctity was a matter between the individual and the Lord Himself; that the function of the human law was not to make men saints but to give them peace and a chance to work out their own individual perfection, their individual sanctity. Sanctity will always remain an individual affair. Blackstone reflected the same wisdom when he pointed out that the purpose of the original public-intoxication statute, which was enacted in England in 1606 and which provided for commitment to the stocks for six hours, was to ensure that the individual did not "do mischief to his neighbors." And, of course, this was the reasoning of Judge Frank Oliver and Chief Magistrate Henry H. Curran when they sought to restrict the arrests of derelicts to instances in which their conduct was disorderly.

We can help some derelicts by a modern therapeutic program. Alcoholics Anonymous does have the answer for some. We can help all of them by a more humane program of day-to-day care and relief. But we must seek the fundamental and ultimate answer in an improved society, a society that will produce fewer misfits, fewer inadequate human beings. We will neither solve nor ameliorate the problem by more vigorous police enforcement or sterner justice.

Chief Parker may well ask: "Would you then continue to permit the derelict to lie in the gutter?" The answer is simple. I would arrest the unfortunate who is a menace to the community, such as the derelict who is loud and boisterous or assaultive. I would have the police escort others for their own safety to a public shelter, to the Muni, as Officer Nelson suggested, there to remain, perhaps, for the cooling-off period of six hours. But there is no moral justification for the present program of wholesale arrests. Its only function is to keep depravity from becoming too assertively public.

Once we appreciate these almost self-evident truths, we must realize how farcical our primitive justice is and has been over the years. Today we recoil at the manner in which past generations used burning and whipping to curb crime. Is it not likely that future generations will read of our imprisonment of drunken derelicts with a similar sense of shock and outrage?

HELPING ALCOHOLICS stay out of the REVOLVING DOOR

BY MARY BARBER

JUST six years ago today, the Compass Club, at 305 Crown Street, was established by the Connecticut Alcoholism Division, Department of Mental Health to offer a constructive program to men who have had a long history of excessive drinking and involvement with police and courts of the state.

Dudley Porter Miller, Ph.D., executive director of the Connecticut Alcoholism Division, states that, "Of the estimated 80,000 alcoholics in Connecticut a minimum of 10,000 of them are chronic police and court case offenders." These men, who are usually without funds, family or friends, present grave problems to the community in which they live. Since the opening of the club there have been nearly 600 admissions representing individuals.

It is generally agreed that to attempt to deal with this situation by repeated arrests and jail commitments is no more constructive than to go around and around in a revolving door. However, John Frings, assistant director of the Alcoholism Division and head of its Chronic Police and Court Case Bureau, reports that "in five years it has been found that the practical program of the Compass Club not only saves the taxpayers money in costs of arrests, trials, jail commitments and hospitalization of these men, but is also able to develop in a substantial number of its members an ability to become productive citizens entirely free from the use of alcohol."

During the 12 months from July, 1959 through June, 1960, the direct costs of operating the programs were $52,000. During this time the men earned a total of nearly $40,000 in private employment and returned to the State nearly $11,000 for care and treatment. The direct costs for 7,974 patient days during this time averaged $6.48 per patient day, or, when payments for care and treatment were deducted, $5.16 per patient day.

One of the most striking things about these figures is that the men, who for years had cost the community considerable amounts via police, court, jail, hospital and welfare costs, earned and returned to the State and its economy 77 per cent of the direct costs of the program.

What kind of a person is the chronic drunkenness offender? He is a man suffering from advanced stages of the illness of alcoholism. He is a chronic problem drinker who depends on alcohol, social and welfare agencies, institutions, and other alcoholics to solve his need for social and economic support. Generally, by the time he has reached middle age

The Compass Club of New Haven has helped many of the city's alcoholics stay out of the revolving door since its beginning six years ago.

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he has lost all connections with home, family or job.

With advancing age and finding it difficult to change, he accepts his fate. He often becomes drunk in public view. As arrests and jail sentences mount, he becomes known as a "repeater." Agency help only sustains him between relapses.

What does this kind of a man do when he is released from jail or hospital? What can he do? Effects of treatment or punishment vanish rapidly in the face of new crises. Without food, shelter, or a job, he can turn to few groups for help. If only a drinking group is open to him, then he will return to this group—usually one which requires heavy drinking. This almost certainly means that relapse will follow. The Revolving Door starts again to make its weary cycle.

But if this man can join a sober group immediately after his release from jail or hospital, he may break the pattern of repeated drunkenness. If he can find the semi-protective environment and program of the Compass Club acceptable, he may be able to transfer his dependence on alcohol to the club and its members. He may reverse the direction of a life from increased dependence, misery and ultimate degradation to a life of self-respect, renewed confidence,

sobriety and productive, responsive citizenship.

Because of the homeless and jobless circumstances of most offenders, the Compass Club, unlike Alcoholics Anonymous and other treatment resources, provides shelter and opportunities for gainful employment. But, as with Alcoholics Anonymous, the most important rule is to stay sober one day at a time.

At the Compass Club he finds: Acceptance.

Companionship with men who have a similar background of problem drinking.

Help toward sobriety through the guidance of rehabilitation counselors.

Individual and group therapy sessions.

Medical supervision.

Aid in finding employment.

Any male resident of Connecticut who has had three or more arrests for drunkenness in the past two years or not less than five such arrests in the preceding five years, who is between 30 and 55 years of age and employable, may join the Compass Club on a voluntary basis. Members are helped to obtain outside employment. They live at the club and when able they pay a maximum of $3 a day as payment for care and treatment after the first week, which is free. They eat two meals a day, breakfast and dinner at the club. Men who go out to work take a lunch supplied by the club.

Each member may stay a maximum of six months but any member who is unable to refrain from drinking while a member of the club immediately becomes ineligible for continued membership; however, each case is considered individually and members may be given the opportunity of three admissions.

Those working in the club program distinguish between a "dry" and a "sober" state. Most problem drinkers have periods when they abstain from alcohol. Most of these "dry" periods are actual endurance contests, or self-imposed punishments. During these periods, with basic conflicts unresolved, tensions mount. Once inner stress becomes unbearable, they "break out" and relapse into uncontrolled drinking.

In a "sober" state the drinker accepts the proposition that drinking will only add to, rather than subtract from, the burden of discomfort. Social as well as problem drinkers have been quite aware of this fact for years, yet to make the idea become a real part of the feelings of the alcoholic entails a most difficult period of adjustment for many problem drinkers.

"On-the-Spot Therapy"

When a man genuinely desires to reverse a long-standing pattern, he needs to be with others who understand his feelings and experiences. Under these conditions, with the guidance of trained counselors who give a form of "on-the-spot" therapy designed to nip tensions in the bud, some men can go from the "dry" to the "sober" state.

Through this program the Compass Club does not pretend to remake offenders overnight, but under the administrative direction of Mr. Frings and the immediate supervision of Runyan Baldwin and a competent staff of counselors, in many cases it does succeed in establishing, without alcohol, a constructive and acceptable way of life for the problem drinker.

It is a heartening commentary on the club's coming-of-age that two new members of its staff are themselves "graduates" of the club's program.

Recognizing relapse as a characteristic of the illness of alcoholism, the staff uses this to transfer de-

pendence on alcohol to dependence on the program. All members are urged to keep in close contact with the program and to consider membership in Alcoholics Anonymous. At the same time, for men who relapse, the staff arranges hospitalization and encourages them to think of re-admission into the club for another try.

Repeaters are not considered to be failures. Research by Earl Rubington, Ph.D., special research scientist for the Alcoholism Division, shows that repeaters often show real improvements. The average stay for first admission is 25 days. For repeaters the average length of stay is 50 days.

After separation from the club, continued help and support is needed for recovery from such a severe and long-standing addictive illness as alcoholism. Some club members join Alcoholics Anonymous. Others find a more helpful association with the Pilot Club which is organized and run by the graduates themselves to form a further bridge into the community. This relationship is extremely valuable to those whose sobriety is often still quite precarious.

Thus after six years of exploratory work in this long-ignored field, the Compass Club has evolved a program which may not only reverse the cycle of the Revolving Door for seemingly hopeless alcoholics, but may enable them to go on to an independent, productive life. Certainly the case records of those men who "have made it" leave an unshakable conviction that the results in human and economic terms are worth every penny spent on the program at the Compass Club.

With this success in mind and with the cooperation and interest of the State and local communities, the Alcoholism Division hopes to open additional similar facilities in Connecticut.

DRUNKENNESS IS BASIC

CONTINUED FROM PAGE 3

thing about his drinking spends three or four days in jail "drying out" before reappearing in court. Before he is offered the probation program he participates in a brief orientation session with probation officers and members of Alcoholics Anonymous. The alcoholic is then offered a chance to try the program if he so desires. To those alcoholics who accept, there are no strings attached other than the request that they attend a meeting about A.A. once a week for three months.

According to the Charlotte plan, when the men are released, the Salvation Army would furnish room and board for them on a temporary basis. Permanent housing would be provided at the Flynn Christian Fellowship House which was established for the purpose of providing a home for homeless men. (As a cooperative boarding house for sober, homeless alcoholics, it has been self-supporting for fifteen months.)

A.A., the Charlotte Council on Alcoholism, the N. C. Employment Security Commission, the Vocational Rehabilitation Department, and the Welfare Department would all cooperate in this probation plan.

The State Probation Department initially declined this program as being outside their scope of work as a "voluntary" program. The Charlotte City Council voted to employ a probation worker but the city attorney ruled it would be illegal for tax monies to be spent for probation or rehabilitation through the city court. The Attorney General supported this.

The tragedy lies not only in the present destructive system but that punishment is legal and rehabilitation is illegal. The sin is not drunkenness but apathy and indifference which prevents the needed change.

A feature designed to help you keep posted on developments in the field of alcoholism.

DURHAM, N. C.: The Durham Council on Alcoholism is working toward establishing an alcoholism rehabilitation center in downtown Durham. Dr. Thomas T. Jones, chairman of the rehabilitation committee of the Durham Council, said that the center would be used to provide medical care for the acutely ill alcoholic, as an out-patient clinic and counseling center, and for psycho-drama presentations and other similar activities.

LONDON, ENGLAND: The Third International Conference on Alcohol and Road Traffic will be held in London September 3-7, 1962. Previous conferences were held in Stockholm in 1950 and Toronto in 1953.

NEW BRUNSWICK, NEW JERSEY: Gifts totalling $375,000, about half the cost of constructing and furnishing a building for the Rutgers Center of Alcohol Studies, have been received by the University from the Christopher D. Smithers Foundation, Inc., and its president, R. Brinkley Smithers. The proposed location of the new building is the State University's new science campus at University Heights.

JACKSON, MISSISSIPPI: The second Southeastern School of Alcohol Studies will be held on the campus of Millsaps College, Jackson, Mississippi, August 5-10, 1962. The school is sponsored by Region IV of the United States Public Health Service and the official alcoholism agency in Alabama, Florida, Georgia, Mississippi, South Carolina and Tennessee. It was organized to meet the needs of professional and non-professional persons who are seeking a better understanding of the problems related to alcohol and alcoholism.

LAURINBURG, N. C.: North Carolina's first working conference on problems of alcohol as related to youth was held at St. Andrews Presbyterian College July 23-26, 1962. The conference was sponsored by the North Carolina Alcoholic Rehabilitation Program; the Department of Health Education, School of Public Health, University of North Carolina; the Alcoholism Programs of North Carolina; the N. C. State Board of Health and the National Institute of Mental Health. Teams representing local alcoholism programs, public schools and public health departments from various communities in the state worked together throughout the conference.

GOLDSBORO, N. C.: The Goldsboro Program on Alcoholism has changed its name to the Wayne County Council on Alcoholism. Mr. A. T. Griffin, Jr., who has headed the Goldsboro Program since its inception in 1960, will serve as the Council's executive director and will be in charge of the activities of the newly organized information center. Other officers elected recently were Dr. Joe Bain, Wayne County Health Department director, vice-chairman; Mrs. R. J. Carter, secretary; and Mrs. Charles S. Norwood, Jr., treasurer.

ALCOHOL AND DRIVING: It's the amount of alcohol in your bloodstream that affects your driving, according to the Institute for Safer Living of the American Mutual Liability Insurance Company. Repeated tests show that any amount above .05 percent in the blood makes a driver hazardous. This amount allows the average driver not more than one or two drinks, and he is far better off if he makes those drinks coffee.

DURHAM, N. C.: A Duke University neurologist, Dr. E. Charles Kunkle, stated in a recent issue of the Journal of the American Medical Association that the alcohol in a single cocktail is enough to bring on a migraine headache in certain persons. This is noted in only a very few cases, Dr. Kunkle explained, and is most evident in persons with a common migraine varient, the "cluster" headache.

NEW YORK, N. Y.: Mr. R. Brinkley Smithers, president of the National Council on Alcoholism, said recently that Communist nations are having problems with alcoholism—what they have denounced in the past as a purely capitalist disease. During the past year or two, he said, indications of the growing problem of alcoholism have come from behind the Iron Curtain. He cited as an example the recent European Institute for the Prevention and Treatment of Alcoholism in Warsaw, Poland in which the problem of alcoholism in that country was discussed.

WINSTON-SALEM, N. C.: The Flynn Christian Fellowship Homes of Winston-Salem, Inc., has been organized to establish and operate a home for alcoholics. Officers of the new organization are Robert B. Sutton, chairman; Guy T. Ward, vice chairman; Marshall C. Abee, secretary; and Guy R. Dudley, treasurer. Several other Flynn Homes are in operation in other North Carolina cities. One has recently been planned for Wilmington, Reidsville, and Greenville.

NEW BRUNSWICK, NEW JERSEY: A research study indicating that hangovers are hard on the heart is among the contents of the Spring, 1962 issue of the Quarterly Journal of Alcohol Studies edited by Mark Keller of the Rutgers Center of Alcohol Studies. Three physicians from the Institute of Occupational Health in Helsinki, Finland conducted the experiment on thirty healthy firemen. These men were asked to do certain standard physical tests the morning after drinking large amounts of alcohol. Fourteen of the men performed as well in the "hangover" state as they had normally, two did better, and 12 performed less well. However, both while at rest and while at work, the heartbeat of the men with hangovers was significantly faster than under normal conditions.

MUNICIPAL COURT

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the exclusive use of this program. The courtroom is air conditioned and comfortable. The men find themselves in an official yet relaxed environment.

Two of the probation officers who understand the problem from personal experience address these groups and explain the details of the court program as well as the program and function of Alcoholics Anonymous. They speak the language that is so vitally necessary and important at this particular stage. Usually three to five members of A. A. also are present and speak to the groups. They volunteer their time. We believe this program works as well as it does because of the dedication of these members of A. A. and their willingness to give of their time. Their counsel is based on personal experience.

At the conclusion of these talks the groups are offered the program, but only after they know all the facts and are familiar with all that is to be offered them. They are given an opportunity to decide whether they want to accept or reject the offer and *no coercion in any form is used.* They are told that in accepting the program only one request is made of them: an investment of one hour of their time to attend a meeting about A. A. which is held at 9:00 a.m. every Saturday morning in courtroom 18 of the criminal division of the Municipal Court, or a meeting held Monday evening at 8:30 p.m. in a courtroom in the civil division of the Municipal Court.

It is emphasized that the Municipal Court Alcoholic Rehabilitation Unit is not a group of Alcoholics Anonymous, but that the principles and philosophy of A. A. are applied.

Upon acceptance of the program the men appear in court and on recommendation of the probation officer are released on personal bond which is, in effect, a suspended sentence. After appearing in court they are interviewed individually by probation officers assigned to the Unit who obtain personal data for record and statistical purposes. When necessary, referrals are arranged for temporary food and lodging. A number of employment placements are made and considerable time is spent in job counseling. The office is open every afternoon to permit the men to discuss personal problems—an experience so necessary for persons in this situation. Referrals are made for clothing. Wherever possible, the services of community agencies are utilized to the fullest extent. Those in need of medical care are referred to hospitals in the area. Careful interviewing and screening has detected a number of active tuberculosis cases. Others have been found to be mental patients who had escaped or "eloped," and were returned to their hospitals.

One of the interesting highlights of the Monday evening meetings is the fact that they are conducted by men who obtain sobriety through the court program. These men make a most significant contribution.

It is heartening to observe the wives, parents, and relatives who attend these meetings. Their attendance not only lends encouragement to those concerned, but adds strength to the program, because it is not only reaching alcoholics, but also those who are affected by the alcoholics in their family relationships.

Coffee is served before and after meetings. The cost is met by nickel and dime contributions by the men themselves. Smoking is permitted.

The success of the expanded program of the Alcoholic Rehabilitation Unit for the 18-month period ending

March 31, 1960, can best be demonstrated by the following data:

Of the 32,889 arrested, a total of 12,209 were interviewed and screened by probation officers of the Unit, 8,303 of them in court and 3,906 in the cell block. A total of 4,440, or 36.4 percent of those interviewed and screened, were placed on quasi probation and released to the Unit. Of those placed under the program of the Unit, 2,002, or 45.9 percent, were rearrested for intoxication. (Many were not rearrested until months after being placed under the Unit's guidance and care, but were not considered successes. The measuring stick of success adopted by the Unit is a person who has not reappeared in court for intoxication during a 6-month period.) Accordingly, 2,438, or 54.1 percent of those released to the Alcoholic Rehabilitation Unit during the 18-month period, did not appear in court on a charge of intoxication within a period of 6 months. It is not claimed that all of the 54.1 percent remained sober during the 6 months, but rather that they have not reappeared in court.

A question has been asked whether a relatively high percentage of "success" is not the result of transients who do not return to Washington following their arrest and release to the program. Our answer is that we do not knowingly place transients in the program.

During the 18-month period from September, 1958 through March, 1960, a total of 842 were referred for temporary food and lodging; 72 employment placements were made as a result of the direct efforts of the Units; 344 were given employment referrals; 22 were given medical referrals; and 40 referrals for clothing.

We may also assess the worth of the Alcoholic Rehabilitation Unit program in terms of dollars and cents saved. During the first 12 months of operation a total of 2,719 were released to the program. Of this number, 1,504 did not reappear in court during a 6-month period and were considered "successes" based on the adopted measuring stick of success. The average sentence in the District of Columbia for persons arrested for intoxication was 21 days and the average person was arrested three times in the course of a year. Thus, the average time spent in jail was 63 days a year. The daily per capita cost for jail commitment, based on figures for the fiscal year 1957, was $2.86. On the basis of these figures, it might be concluded that the 1,504 who "made good" saved the District of Columbia taxpayers an estimated $270,990.72 during the year.

Perhaps sometime we will be able to expand our program so that we may talk with those who are released after completing 60-day, 90-day, and 180-day sentences and returned to society without funds—in many instances without adequate clothing, no place to live, no job, and no idea where their next meal is coming from. Perhaps we eventually will be able to help many of these men and women in the same way and along the same lines as those we are working with today.

The savings to the taxpayer based on the per capita cost of confinement—even though they are only an estimate—are impressive. There are, in addition, the savings that derive from gainful and productive employment, increased earning capacity, payment of taxes, and the financial savings to welfare agencies which would have to care for these men and their families while they are unemployed or serving a jail sentence. But far more significant than these monetary gains are the intangible benefits that result from salvaging a human being and preserving his family and his home.

Currently in North Carolina there are fourteen

LOCAL PROGRAMS ON ALCOHOLISM

Educating the public is one of the major functions of these community groups and the key to prevention of alcoholism.

ASHEVILLE—

Citizens' Committee on Alcoholism
SGT. CARROL R. OWENS, CHAIRMAN
Municipal Building, Asheville

Educational Division, Board of Alcohol Control, West Wing, Parkway Office Building
DON DANCY, EDUCATIONAL DIRECTOR
Phone :ALpine 3-7567

CHARLOTTE—

Charlotte Council on Alcoholism
1125 East Morehead Street
REV. JOSEPH KELLERMAN, DIRECTOR
WILLIAM HALES, ASSOCIATE DIRECTOR
Phone: FRanklin 5-5521

DURHAM—

Durham Council on Alcoholism
602 Snow Building
MRS. OLGA DAVIS, EXECUTIVE DIRECTOR — Phone: 682-5227

GOLDSBORO—

Wayne County Program on Alcoholism
P. O. Box 1320 — Phone: 734-0541
A. T. GRIFFIN, JR., EXECUTIVE DIRECTOR

GREENSBORO—

Greensboro Council on Alcoholism
216 W. Market St., Room 206 Irvin Arcade—Phone: 275-6471
WORTH WILLIAMS, EXECUTIVE DIRECTOR

HENDERSON—

Vance County Program on Alcoholism—Phone: GEneva 8-4714 or GEneva 8-4730
DR. J. N. NEEDHAM, DIRECTOR
2035 Raleigh Road

LAURINBURG

Scotland County Citizens Committee on Alcoholism
308 State Bank Building—
Vance County Health Center,
P. O. Box 1229
M. L. WALTERS, EXECUTIVE SECRETARY — Phone 276-2209

NEW BERN—

Craven County Council on Alcoholism, Inc.
409½ Broad Street—P. O. Box 1466
GRAY WHEELER, EXECUTIVE SECRETARY — Phone: 637-5719

NEWTON—

Educational Division, Catawba County ABC Board
REV. R. P. SIEVING, 130 Pinehurst Lane — Phone: INgersoll 4-3400

REIDSVILLE—

Rockingham County Committee on Alcoholism
225 West Morehead Street,
P. O. Box 355
MRS. ANNE WALL, EXECUTIVE SECRETARY—Phone: DIckens 9-4369

SALISBURY—

Educational Division Rowan County ABC Board, P. O. Box 114
PETER COOPER, DIRECTOR
Phone: 633-1641

SOUTHERN PINES—

Moore County Alcoholic Education Committee, P. O. Box 1098
REV. MARTIN CALDWELL, DIRECTOR
Phone: OXford 2-3171

WILMINGTON—

New Hanover County Council on Alcoholism, 316 Insurance Building
MRS. MARGARET DAVIS, EXECUTIVE SECRETARY

WINSTON-SALEM—

Alcoholism Program of Forsyth County
802 O'Hanlon Bldg., 105 W. 4th St.
MARSHALL C. ABEE, EXECUTIVE DIRECTOR — Phone: PArk 5-5359

OUT-PATIENT SERVICES

FOR

ALCOHOLICS AND THEIR FAMILIES

ARE PROVIDED BY THE FOLLOWING

MENTAL HEALTH FACILITIES

Competent Help Is Available At The Local Level

Mental Health Center of Western North Carolina, Inc.
415 City Hall
Asheville, N. C.
Phone: ALpine 4-2331

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
Chapel Hill, N. C.
Phone: 942-4131, Extension 336

Mental Health Center of Charlotte and Mecklenburg County, Inc.
1200 Blythe Blvd.
Charlotte 3, N. C.
Phone: FRanklin 5-8861

Cabarrus County Health Department
Concord, N. C.
Phone: STate 2-4121

Cleveland County Mental Health Clinic
409 East Marion St.
Shelby, N. C.

Cumberland County Guidance Center
Cape Fear Valley Hospital
Fayetteville, N. C.
Phone: HUdson 4-8123

Forsyth County Program On Alcoholism
802 O'Hanlon Bldg.,
105 W. 4th St.
Winston-Salem, N. C.
Phone: PArk 5-5359

Gaston County Health Department
Gastonia, N. C.
Phone: UNiversity 4-4331

Guilford County Mental Health Center
300 East Northwood Street
Greensboro, N. C.
Phone: BRoadway 3-9426

Guilford County Mental Health Center
936 Montlieu Avenue
High Point, N. C.
Phone: 9929

Pitt County Mental Health Clinic
Pitt County Health Department
P. O. Box 584
Greenville, N. C.
Phone: PLaza 2-7151

Mental Health Center of Raleigh and Wake County, Inc.
615 Wills Forest Road
Raleigh, N. C.
Phone: TEmple 4-6484

Rowan County Mental Health Clinic
Community Building
Main and Council Streets
Salisbury, N. C.
Phone: MElrose 3-3616

Wilson County Mental Health Clinic
Encas Rural Station
Wilson, N. C.
Phone: 2-372239

Toward helping patients to re-establish satisfactory social relations, all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bi-monthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department. Please request films as far in advance as possible and state second and third choices.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Displays—primarily for local public libraries; also available to school librarians and principals. All requests should be made through local public library to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
P. O. Box 9494
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

VOL. 12, NO. 3 SEPT.-OCT., 1962

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Medical Director, one other physician, a clinical psychologist, a psychiatric social worker, a chaplain and admitting officer, a vocational rehabilitation counselor, a recreation director-occupational therapist, and a full attendant staff.

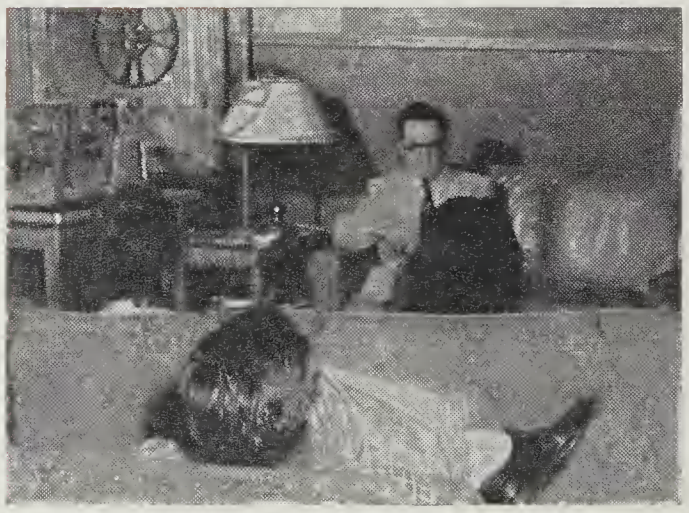
The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment in response to written or telephone request to the Medical Director of the Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment. All appointments must be confirmed by mail.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Services Agency, and a complete medical history, compiled by the patient's family physician, are necessary.



3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M., to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
Patients must be sober upon admission, and in good physical condition. Patients may have visitors after they've been at the Center for 2 weeks. Visiting hours are from 1:00 - 4:00 P.M. on Saturday and Sunday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

NORBERT L. KELLY, Ph.D.
Associate Director

DONALD MACDONALD, M.D.
Medical Director

GEORGE H. ADAMS
Educational Director

INVENTORY

VOLUME 12 NUMBER 3

SEPTEMBER-OCTOBER, 1962

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices 216 N. Dawson St., Raleigh, North Carolina.

This journal is printed as a public information service. Persons desiring a place on the free mailing list must send in a written request, with the exception that *new* requests from *individuals* residing outside North Carolina can no longer be accepted. The views expressed in articles published in *Inventory* are those of the authors and not necessarily those of the NCARP. Manuscripts are invited with understanding that no fees can be paid.

Write: INVENTORY, P. O. Box 9494, Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

Who Gave Up?

Surrender means victory for the alcoholic and a chance to begin new.

A great deal has been written and said about surrender in the recovery of the alcoholic. Sometimes in a group I use this word, surrender, and I can see the cold chills run up and down the back of the novice thinking, "Surrender means defeat. Surrender means giving up when one is fighting it. When you are fighting you are called upon all the time to defend yourself against almost anything and everybody."

This really isn't what surrender, in terms of alcholism, truly means. This isn't what Dr. Harry M. Tiebout, the noted psychiatrist, says when he uses the term. By surrender he means a self-willingness to give up a pathway of destruction, of defiance, that keeps you out of tune with the rest of the world.

It is only through surrender, and by surrender remember that we mean simply giving up one way in order to learn another way, that an individual is freed to grow strong. Through surrender you may find yourself emotionally naked and afraid in the beginning. Later, you are freed of the old fixed ideas of having to fight it out your way and to look around at the rest of the world and pick and choose the techniques and the defenses and the ways of thinking that make it possible to live comfortably with people.

It's really quite nice not to have to be on top—not to have to always be right—not to have to be on the defensive. You can feel, "I am one person, among many, with the absolute right to my own feelings, but with no necessity of being the only one who is right." Only through defeat does the average champion grow strong and become freed of his preoccupation and able to develop all the multitude of things that he *can* do in life.

You see, when you are completely consumed with trying to prove the unprovable, which is that you *can* drink alcohol without getting into difficulty, you are helpless. It is only when you are freed of this that you are able to look at all the other things you *can* do, including "Don't have to drink if I don't want to."

TWO SHORT ARTICLES

By VERNELLE FOX, M.D.

These articles, originally published in The New Life, are reprinted by permission of the author who is Medical Director of the Georgian Alcoholism Clinic.

After this problem is resolved, then you will be totally free and capable of doing many things that you have not been able to do in the last few years.

This may sound quite simplified and elementary, but it is probably the one "insurmountable" step that trips up more alcoholics than any other. Somehow the alcoholic hangs so long and so steadfastly to the idea that he must conquer alcohol that he completely forgets all the other things that *can* be conquered, *can* be worked out, and *can* be produced in his life. When fighting the difficulties of "How can I give up without being defeated?", remember that to surrender in one small area may free you to take over or to be victorious in all the other areas in life.

The Choice

The choice between isolation and sharing himself with others is an important one for the alcoholic.

EVERYONE, but everyone—has to make some major decision about the direction of his or her life. One of the most fundamental of these is the choice between isolation and being related to others. Nowhere is the necessity for this decision more clearly seen than in the struggle of the alcoholic to obtain sobriety.

We are born into this world alone and we leave it alone. These are two major journeys on which no one can accompany us. In between there is a long, sometime stormy, process called living. Whether to live it alone or close to people, or protective isolation versus relatedness, is our decision to make.

What is protective isolation? It's living on an island. Isolation is a good word. It's a southern belle hoop skirt kind of living—it goes all around people but touches none of them. Sure you are with people, frequently mobs of them, but never really close to them—never really emotionally involved. It's safe because if you never share any of yourself with people they can't really hurt you.

There are as many ways of maintaining this isolation as there are people. Stay real busy, control everybody, stay drunk—they all work fairly well. If in doubt, use a combination of tricks. There is only one thing wrong. This isolation, while safe, leaves you feeling lonely, unwanted, unneeded and lost. To feel like you belong to God you must first feel like you belong to people.

So the other choice is to risk yourself and become really involved with people. Share your true self and accept their true selves. Now this is not so easy. In the first place our "true" selves are usually not as pretty as we would like to think. The other fellow may not accept us if he ever really knew us and then we would have to face the pain of being rejected. Then, again, if other people really know us they will know our sore spots and be much better equipped to hurt us if they want to.

This is frightening—it's like taking off your armor in a battle. You have to trust people to love you more than they want to hurt you. You're out of control of the situation.

Love or Perish

In a primitive kind of way the choice is simply this: To go out and search for the emotional food of life, love and a sense of belonging, taking a chance on being badly hurt or even destroyed—or to sit safely in the cave and slowly starve to death. In more sophisticated terms—to wall yourself off with alcohol and other kinds of running, or to take a chance on joining the human race.

It is real easy to talk about but it's far from an easy decision to make and stick to. Many people let a large part or all of life go by without ever making the choice. They manage somehow to exist in a state of confusion somewhere between being alive and dead. It's a cold, hungry, dark, and empty place to be.

Sometimes, if offered a hand to hold to, they can find the courage to brave the dangers of getting close to other people. When it happens, it's painful to watch, but the most beautiful sight in the world. It's an emotional birth into a new life.

Physician's Request

A group of young people in a local church have asked me to talk to them on "The Effects of Alcohol on the Body." They have already heard several talks by other persons concerning different aspects of the alcohol problem. I want this talk to be as interesting as possible. Do you have any books or other material you can loan me to help me make an interesting presentation of this topic?

M. M. Lownes, Jr., M.D.
Mount Olive, N. C.

Splendid Article

A friend of mine, active in A. A., has sent me an issue of *Inventory,* January-February, 1962, calling my attention to the splendid article, "Police, Medicine and Alcoholism."

As a Chaplain of the New York City Police Department, I have been serving as contact man for A. A. cases, and recently have been able to give lectures to officers and the instructors assigned to "Inservice Training." Thus I really appreciate Dr. Trawick's article and I shall recommend it to the staff of our Police Academy.

Msgr. Joseph A. Dunne
New York, New York

A.A. Member Writes

I would appreciate it very much if you would add me to your *Inventory* mailing list. I have just joined the Henderson group. My wife and I find inventory very informative, inspirational and interesting.

Anonymous
Henderson, N. C.

Request for Literature

As a part of the in-service education program for nurses at the Veteran's Hospital in Fayetteville, I have been asked to speak on "The Nurse's Role in the Care of the Alcoholic Patient." This session will be held sometime in October, and I have been told that approximately one hundred nurses will be attending this meeting.

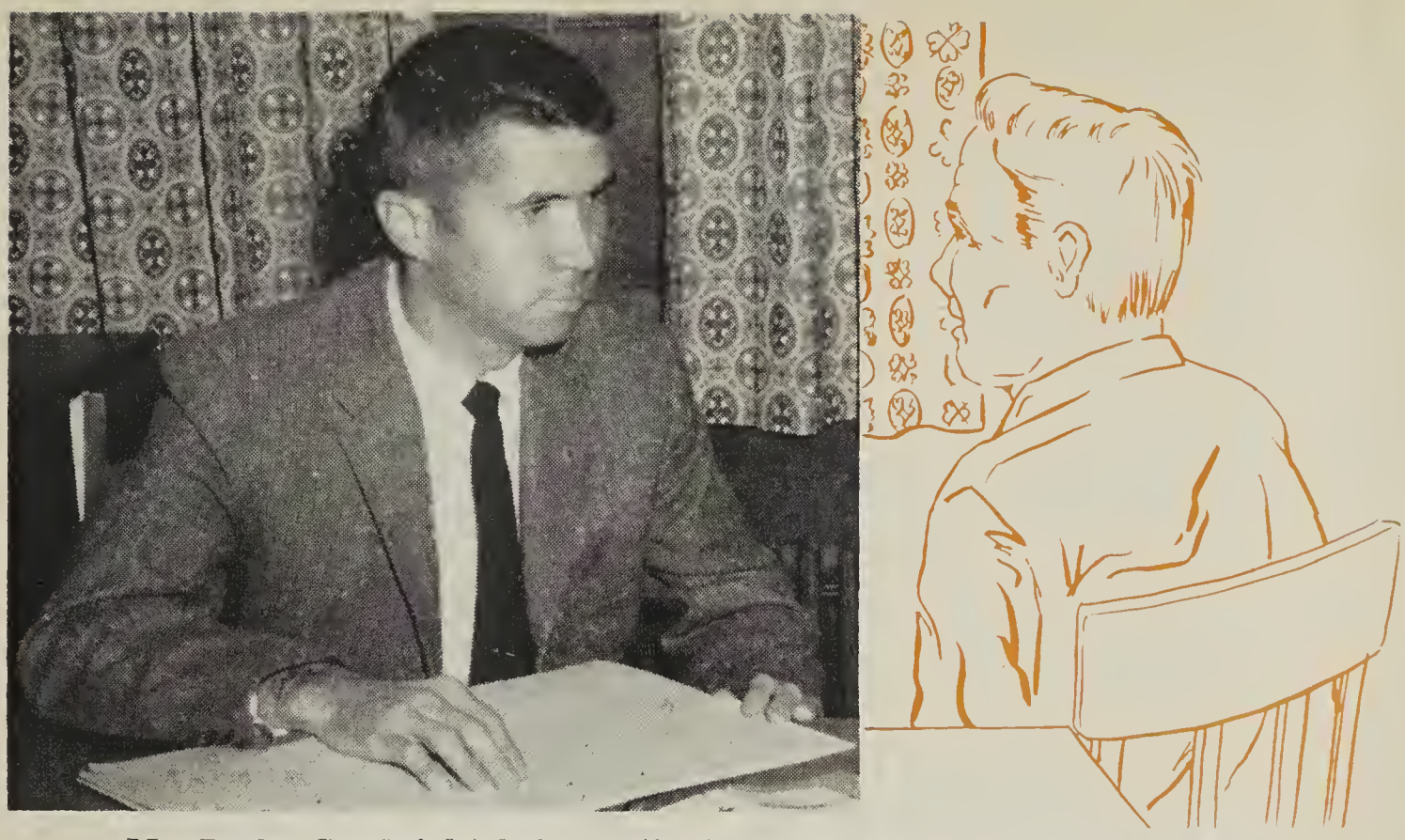
Would you send me any literature that you might have which would be appropriate for distribution among this group? I have found the Nurses' Handbook very helpful, as well as a number of your other pamphlets and folders.

Martha Clyde Davis
Instructor, Psychiatric Nursing
Chapel Hill, N. C.

Alcoholics in Family

Would you please add my name to your mailing list for *Inventory?* I have read a friend's copies and have gained much from them. Having three alcoholics in our family, we need all of the information possible. A. A. has been of great help to one and two have been to Butner. They are different persons since their return home. Since alcoholism is a family illness, we would appreciate your magazine.

Anonymous
Forest City, N. C.



Mr. Parks Goodnight helps patients at the A.R.C. with job problems.

VOCATIONAL COUNSELING THE RECOVERED ALCOHOLIC

By PARKS R. GOODNIGHT, M.S.

VOCATIONAL GUIDANCE DIRECTOR, N. C. ALCOHOLIC REHABILITATION CENTER

The vocational counselor can help the alcoholic through job program-planning, placement, folow-up and by his encouragement and support.

THE North Carolina Alcoholic Rehabilitation Center since August of 1959 has offered vocational counseling to its patients as a routine part of treatment through the services of a professional vocational rehabilitation counselor. The employment of a vocational counselor was not only a new venture for the Center, but working with alcoholics was also a new venture for the counselor whose training and previous experience had been that of working with the visually handicapped.

In the beginning, as with most new ventures, there were numerous questions to be answered. The two which appeared more basic than the rest were: Does the recovered alcoholic need vocational counseling? If so, how may the counselor best utilize his skills and develop new skills in counseling with the recovered alcoholic?

There were no initial guide lines for answering these questions or for developing the program except trial and error methods utilizing the skills

and techniques of the counselor's earlier experience. But, after almost three years of experience, the first question, "Does the recovered alcoholic need vocational counseling?," must be answered in the affirmative as one of the basic needs. An individual, whether he be an alcoholic or not, has to have a sense of well being or self esteem which in part comes from his knowing that he is providing for himself and his family and contributing economically to his community.

Useful Clues

Furthermore, some clues and information have evolved from the counselor's experience which vocational counselors in other settings may find useful in their day to day work.

Before going further, it may be wise to define what is meant by the phrase, "recovered alcoholic," or at least its usage in this paper.

The recovery of the alcoholic individual may be viewed on two levels. The first phase in the recovery process of the individual with an alcoholic problem is the attainment of sobriety; that is, cessation of the active use of alcohol. Although giving up the use of alcohol is essential in the recovery and rehabilitation of the alcoholic, it is by no means all that is necessary. The final phase of recovery consists of the adjustments or re-adjustments of personality and behavior that must be made by the individual which will help him acquire a greater degree of emotional maturity or a satisfactory balance between the various biological, psychological and environmental stresses which absorb his psychic energies. The operational definition of recovery from alcoholism, therefore, refers to an on going process of adjustment over an extended period of time.

Now with the above definition in mind let us turn our attention back to the alcoholic's need for vocational counseling.

The point that individuals with an alcoholic problem need vocational rehabilitation and counseling finds support in the study carried out in 1947 by the National Committee on Mental Hygiene in which the researchers state, "A job is essential for the rehabilitation of many patients on purely practical grounds. They need to support themselves, and they need a job to enable them to do so. It is obviously to the interest of the country as a whole that as many people as possible be self supporting. But economic considerations are by no means the only ones. A man's worth in his own eyes, as well as in the eyes of his neighbors, is to a considerable extent determined by his ability to earn a living. Getting and holding a job is evidence to the patient that he has made a good recovery and strengthens his confidence. The job itself, if well chosen, holds many satisfactions."

Services Provided

Although the services of other professional workers, such as social workers or psychiatrists, may frequently be required in furthering the rehabilitation of the recovered alcoholic, the vocational counselor can help the alcoholic to help himself in his emotional growth through various services which he provides such as job program-planning, placement, follow-up, and last, but not least, good solid support.

The need for vocational rehabilitation and guidance may also be seen on a statistical basis through the following vocational data gathered by the vocational guidance director of the Center.

Of the patients admitted in 1960, 129 out of 553 or 23.62 per cent were

unemployed. This is almost four times the national average (6%). Of this number, ten per cent had a need for re-training or further education and eighty per cent needed placement services. All needed follow-up support and guidance.

The Center operates on a voluntary admission policy and provides a group psychotherapy program of twenty-eight days' duration. All patients were seen by the counselor in an individual interview within three days after admission to determine their vocational status—employed, unemployed, self employed, or retired, for example—and the question of job satisfaction was investigated. Those found to be unemployed or dissatisfied in some degree with their present jobs were screened out and seen at a later time to discuss their vocational future.

Of the twenty-three per cent found to be unemployed, all were in need of some type of vocational service. All needed counseling concerning future plans, not only in relationship to the job, but in regard to family, locational change, how to approach prospective employers, interest and aptitude and, in general, a plan of action to follow through on after leaving the Center.

It is also well to recognize the fact that many alcoholics in the first phase of recovery as previously described, that is, before undergoing systematic treatment, need vocational rehabilitation and guidance as well. For example, the employment counselors of the Employment Security Commission interview a sizeable number of alcoholics with vocational problems. They, too, have seen the need for all the vocational services described above.

In considering the techniques of counseling alcoholics, the first and most important step the vocational counselor should take is that of self-appraisal concerning his own attitudes toward alcoholism. Unless he does this, his relationship as a vocational counselor to alcoholics is impaired from the beginning. He must be willing to accept a recovered alcoholic as he is and not as he, the counselor, would like him to be. He must be willing and able to withstand anxiety and frustration and to accept criticism as well as give advice. He must be a warm, outgoing person who is capable of commanding respect through his firmness and truthfulness, ingenuity, and willingness to go the last mile.

Vocational counseling at the Center is conducted both individually and in groups. As already stated, each patient is seen individually during his first few days at the Center. Information is obtained concerning employment status, job satisfaction and relationship of the patient's drinking problem to his job during this initial interview. He is informed as to what the counselor has to offer him and encouraged to take full advantage of all the services the Center provides its patients.

Counseling Techniques

A combination casework and vocational counseling interview follows the initial interview. The counselor, while giving support to the patient, endeavors to learn all he can about him, attempts to motivate the patient into action, and restates what he has to offer. He does not promise a job, but tells the patient he will give all possible aid he can. He tries to find out the patient's interests and abilities and offers the patient psychological testing through the Employment Security Commission if he desires it, for example, the Kuder Preference, Record Vocational, and General Aptitude Test Battery. The counselor recognizes the patient's dependency needs but, at the same

time, must become directive and emphasize to the patient that he has the responsibility of deciding what he wants to do.

If possible, a vocational plan is undertaken at this time. If not, the open door policy exists so that the patient may return whenever he desires. Unless the patient returns of his own initiative, he is not contacted again until the last week, but he knows what the counselor does and that he can call on him if he wants him to contact former employers or other persons in the community who might be able to help him. Letters are written by the counselor to former employers or to others who might be of assistance in helping the patient obtain employment only by request and consent of the patient who is called into the counselor's office as soon as replies are received.

The counselor, however, encourages the patients to write prospective employers themselves as further motivation and stimulation toward nondependency. Experience has shown that those who write employers have a higher regard for themselves for taking the responsibility. One very important task of the counselor is to help the recovered alcoholic to be responsible, independent and of renewed self esteem.

Exchange of Ideas

The counselor works with those who have vocational problems in the small group setting where free exchange of ideas is encouraged. He also conducts group sessions where all patients meet to discuss vocational guidance. Here, the following topics are discussed:

1. Interests and abilities.
2. Assets and liabilities.
3. Persistence and patience in contacting employers.
4. Diversification of interest and industries.
5. Awareness of what one has to offer an employer.
6. Knowledge of nature of a prospective employer's business.
7. Knowledge of how to dress and how to act.
8. Information regarding sources of jobs, such as public and private employment agencies.
9. Letter and resume composition.
10. Question and answer period.

In regard to item ten, the most common question coming before the group is "Do I tell the employer that I am an alcoholic?" It is important that the recovered alcoholic be frank with the employer and himself, but a good rule of thumb seems to be to play the cards as the situation calls for. In any case, if the employer or the application blank asks for information concerning the drinking problem, the recovered alcoholic should be truthful.

Summary

In summation, it can be emphatically stated that there is a need for vocational rehabilitation services for the recovered alcoholic. Furthermore, through the actual experience of the author, the vocational counselor obtains some clues about how to counsel with the recovered alcoholic and techniques whereby they may be implemented. Both individual and group therapy are used at the Center to achieve the maximum self-involvement of the recovered alcoholic in moving from a low self-concept to a high self-concept and independence. The counselor must, however, be ready and willing to give assistance and support whenever needed or requested to sustain the recovered alcoholic in the forward process of adjustment he is attempting to make in his life situation, not only in the vocational sphere but also in other areas of difficulty where he finds himself.

THERE has seemed to be in the past and, indeed, up to and into the present, a tendency on the part of scientific medicine to ignore the problem presented by the alcoholic. This has been in part, no doubt, the result of the fact that there are and have been in our society powerful forces which have isolated the alcoholic from community concern on sociological, moral, religious, and other grounds.

This is not a unique human pattern of behavior. The same attitudes have existed in the past in relation to the insane, in relation to oddities in human behavior, as during the witch hunts of early Colonial days, and, indeed, in relation to certain racial characteristics different from the dominant group.

However, it is not likely that even in the face of social disapproval the alcoholic would have been so completely

RESPONSIBILITIES of Medicine in Alcoholism

It is medicine's responsibility to accept alcoholism as an illness, admit alcoholics for treatment in general hospitals, and teach the facts about alcoholism in medical schools.

Reprinted by permission from the Michigan Alcoholism Review.

By HAROLD H. GAY, M.D.
CHAIRMAN, MICHIGAN STATE BOARD OF ALCOHOLISM

ignored by scientific medicine if some of the criteria for recognizing and treating disease had been present in the instance of the disease (as we now recognize it) of alcoholism. The trained physician is most comfortable in the treatment setting if he can establish for any disease he is called upon to treat, a cause. He would like to know:

1. Is this a familial disease? Is it inherited or is the tendency inherited?

2. Is this a congenital disease? Is it a result of birth injury, of influences acting during pregnancy, etc.?

3. Is this disease due to external factors? Is it a germ disease; due to injury, poisoning, etc.?

4. Is this a degenerative disease? Is it due to a wearing out of vital tissues or organs; cancer, senility, etc.?

5. Is this an emotional disease? Is it a neurosis or insanity, etc.?

The physician looks upon all deviations from normal as disease, whether the deviation be in the realm of the physical, the physiological, or the psychological. It is unlikely that any thoughtful physician conversant with the facts would fail to recognize alcoholism as a disease. There are still many factors about this disease, however, which puzzle him and the first stumbling block is etiology.

The physician is aware that this is probably not a familial disease. It is certainly difficult to prove alcoholism to be an inheritable characteristic. Indeed, usually the opposite is the case.

The physician will find difficulty defining alcoholism as a physiological disease, though the first impulse may be to place it in this category considering it as an addiction. However, in the mind of the physician, addictions do not arise in isolated individuals from materials to which a major portion of the population is exposed. He considers a substance with potentials for producing addiction to be non-selective and capable of producing addiction in one and all exposed to its use.

The physician will find the least difficulty in looking upon alcoholism as a psychological illness, but even here he will find difficulty since he is told that the psychosis cannot be considered separate and aside from its association with alcohol—that the one does not exist without the other —and that splitting the alcohol off from the duo leaves a psychologically healthy, normal individual.

Cause Unknown

Stated simply, the physician considers alcoholism a very confusing disease, which could be, and usually was, said of every disease until its etiology was fully understood and treatment was placed on a sound scientific basis. The fact does remain, however, that alcoholism is truly a human disease. It must be accepted that the cause is as yet unknown.

There are certainly features of the disease which suggest that basically it is a disorder of human physiology. It can be easily and is daily being demonstrated that a group of apparently normal, healthy humans can be exposed to the same basic circumstances in relation to alcohol consumption and that the exposure will result in "normal" social drinking for most of the group and in alcoholism for certain unpredictable isolated individuals. It can further be shown that these isolated individuals are not necessarily and exclusively involved in emotional problems and frustrations in excess of all others in the group at the time of or before the development of the disease of alcoholism.

Indeed, the fact of the disease status of alcoholism need scarcely

be belabored. Those who have come to know and to deal with alcoholics or with an alcoholic will find difficulty only in finding alcoholism anything but a disease.

Accepting alcoholism as a disease this becomes, a priori, a problem for and a responsibility of medicine. The fact that disease has been treated in the past and is being treated in the present with considerable success by the laity cannot be advocated as a valid reason for medicine shirking the problem; and, this must be true if for no other reason than that this most serious of all public health problems will not fully yield until an etiology (or perhaps etiologies) have been discovered as a base upon which to erect adequate and productive treatment regimens.

How must medicine proceed to meet the responsibilities created by alcoholism?

First, the known facts regarding this disease must be taught in medical schools. The social, the family, and the moral implications of the disease are now being taught in undergraduate disciplines. Medicine must not and cannot long afford not to teach the medical facts relating to the disease.

Teaching is, perhaps, the greatest known stimulus to inquiry. Many thoughtful people find it irritating, irksome, scientifically unscrupulous to teach half-truths or doubtful truths. This alone will stimulate certain people to devote their intellectual curiosity to the solution of the many questions raised by the known facts of the disease. From this, eventually will come solutions.

Second, hospital doors must be opened to the alcoholic. Many general hospitals already accept alcoholics as regular patients. All should do so. In the full light of sober reality, however, it must be recognized that no hospital can admit patients for treatment whom no one on its staff is able or willing to treat. To admit alcoholics simply for "drying out" purposes would be just as improper and just as indefensible as to admit diabetics for the sole purpose of reducing the blood sugar to normal or to admit acute appendicitis patients for the sole purpose of allaying their pain.

This means that somewhere in the community, as a beginning, there must be at least one physician who has the understanding to accept the alcoholic as a diseased person seeking help, perhaps unconsciously, but none the less seeking help. The concept of the person with an emotional problem seeking help unconsciously is familiar to every physician. To see in the alcoholic's determined, sometimes violent opposition to proffered help, an unconscious seeking for help in a troubled, fantastic world should present no great hurdle to the objective physician versed in the modern concept of human behavior.

Common Rationalization

The physician who concerns himself about the alcoholic will at first and inevitably be discouraged by failure and indeed this is the most commonly heard rationalization for refusal to become involved with the treatment of the alcoholic. Yet, there are few diseases where the physician does not willingly accept the expectation of a certain percentage of failure and this in areas where the sufferer is consciously anxious to be cured.

Who, among physicians, has not had the frustration of seeing a fully controlled stable diabetic admitted to the hospital in diabetic coma? What experienced physician has not seen or at least learned of an adequately controlled epileptic lying in public in

(Continued on page 31)

A feature designed to help you keep posted on developments in the field of alcoholism.

BISMARCK, NORTH DAKOTA: The 1962 annual meeting of the North American Association of Alcoholism Programs will be held October 7-11 in Bismarck at the Grand Pacific Hotel. A featured event of the meeting will be an address by Dr. Leonard W. Larson, President of the American Medical Association. Dr. Norbert L. Kelly, associate director of the NCARP and second vice-president of the NAAAP, will attend the meeting.

MOLINE, ILLINOIS: The fifteenth annual meeting of "International Doctors in A.A." was held in Moline July 20-22. Approximately 100 physicians, dentists and guests attended the meeting. Membership in the organization is open to both physicians and dentists interested in medical or psychiatric aspects of alcoholism and to doctors who are members of Alcoholics Anonymous. The next meeting is scheduled for July 19, 1963 in White Sulphur Springs, West Virginia.

CHAPEL HILL, N. C.: An alcohol education course for graduate students of the U.N.C. Department of Health Education was held at the University School of Public Health July 27 - August 6. Dr. H. B. Walker, associate professor of Public Health Education, served as coordinator of the course which included instruction in the physiology and metabolism of alcohol, social problems, the functions of the educator in alcohol problems, and other areas of study. Dr. Norbert L. Kelly served as a faculty instructor together with Dr. Robert Coker of the University School of Public Health; Dr. Fred Ellis, associate professor of pharmacology at the UNC Medical School; and Joe Fred Sills, UNC research associate in Health Education.

NEW BRUNSWICK, NEW JERSEY: The current issue of the Quarterly Journal of Studies on Alcohol carries a report suggesting that amino acids may be useful in the treatment of delirium tremens. A team of physicians from the Department of Surgery of the Harlem Hospital Center in New York City report that they have found that amino acids can reduce the severity and duration of delirium tremens and the need to administer sedation. Their conclusion was based on a study of 121 alcoholic patients who had developed delirium tremens. The physicians also discovered that a reduction in the normal amino acid level of the blood preceded attacks of delirium tremens and they were able to prevent these attacks by injecting amino acids when an attack seemed about to occur.

GREENSBORO, N. C.: Dr. Norbert L. Kelly and George H. Adams, ARP education director, recently met in Greensboro with members of the Alcoholism Programs of North Carolina executive committee to plan the semi-annual meeting of the organization which will be held in Raleigh on November 2.

RALEIGH, N. C.: George H. Adams will conduct a leadership training school for Presbyterian laymen October 7-10 at the First Presbyterian Church in Raleigh. The course will consist of a series of four sessions on alcohol and alcohol problems, prevention and treatment of alcoholism and rehabilitation of alcoholics.

WAYNESVILLE, N. C.: ARP staff members Dr. Norbert L. Kelly and George H. Adams have recently returned from Waynesville where they participated in planning sessions for Haywood County's Alcohol Education Week to be held the week of October 21. Recently named chairman for the special week is Admiral W. N. Thomas, former chaplain in the United States Navy, retired. The project is being sponsored by the Haywood County Mental Health Association in cooperation with the county Medical Society and Ministerial Association and with the NCARP.

A series of workshops are being scheduled during the week for school superintendents, principals and supervisors; staffs of the Health Department, the Welfare Department and employment services; law enforcement officers and court officials; medical and administrative staffs and the Board of Directors of Haywood County Hospital; Ministerial Association members; industrial executives; wives of physicians and ministers; and mental health leaders of the home demonstration clubs. These workshops will be held in Waynesville and Canton.

Other meetings being planned for Alcohol Education Week include a Sunday evening church service for the general public and an open meeting of Alcoholics Anonymous.

Speakers will be available to meet with civic clubs, and public libraries in Waynesville and Canton will feature special book exhibits as well as pamphlets for distribution.

Dr. Kelly, Mr. Adams and Miss Roberta Lytle, a psychiatric social worker at the Alcoholic Rehabilitation Center at Butner, will all participate in the week's activities.

ASHEVILLE, N. C.: During Haywood County's Alcohol Education Week, a variety of educational activities will also be taking place in Asheville in nearby Buncombe County. Dr. Kelly, Mr. Adams and Miss Lytle will participate in study courses for teachers, public health nurses, caseworkers and ministers which will be continued in later sessions throughout the Fall months.

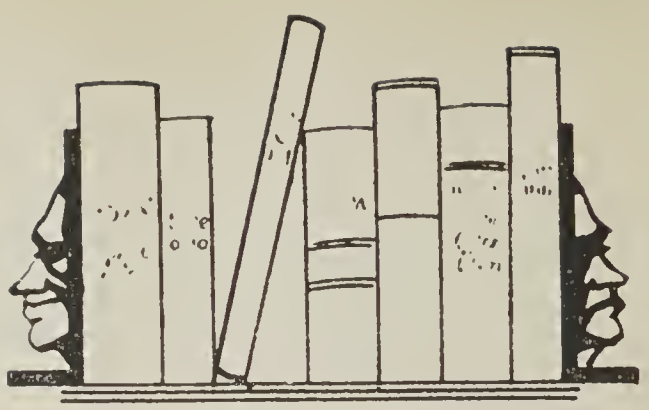
"Alcohol Education For Youth" will be the theme of the teachers' study course in which the main emphasis will be on such subjects as alcohol, personality and society; teen-age culture as related to the use of alcohol; approaches to alcohol education; and a study of resource materials for teachers.

The clergymen's study conference will be concentrated in the areas of personality development, counseling techniques, the illness of alcoholism, and pastoral counseling with the alcoholic and members of his family.

An in-service training course for caseworkers and public health nurses will feature such topics as the family's involvement in alcoholism; teen-age culture as related to the use of alcohol; the social worker's role in working with alcoholics and their families; socio-cultural problems in alcoholism; and other topics of interest.

BOOK REVIEW

Alcoholism and Society. By Morris E. Chafetz, M.D. and Harold W. Demone, Jr. (New York: Oxford University Press, 1962, 319 p.p., $6.95.)



By DONALD E. MACDONALD, M.D.

THE collaboration of a psychiatrist and a sociologist in presenting an up to date review of the subject of alcoholism in its various ramifications has resulted in a concise, readable, and authoritative volume.

Proceeding from their concept of alcoholism as a chronic behavioral disorder arising from multiple etiological factors, the authors go on to review current definitions of alcoholism. They deemphasize the importance of tolerance as a feature of alcoholic addiction, pointing out that case histories often fail to illustrate the development of this phenomenon. They also find no evidence for any abnormal physiological response to alcohol in individuals who are unable to drink because their system rejects alcohol nor, do they subscribe to the theory of an allergic basis for alcoholism. Cultural factors in the development of alcoholism are considered with reference to both literate and preliterate societies. In a review of etiological factors the authors challenge Strecker's contention that the potential for addiction exists in us all, pointing out that the potential can exist only if the genetic, psychophysiological and socio-cultural elements necessary to creating the severe disturbance of alcohol addiction are already present.

Contemporary governmental alcoholism programs are described both in the United States and overseas, including an intriguing glimpse of alcoholism treatment methods behind the iron curtain. In spite of the development of treatment and educational programs in the various States, the authors echo an all too familiar refrain in pointing out once again the lack of research funds in the budgets of these programs. The growth of such organizations as the Yale Center of Alcohol Studies and the National Council of Alcoholism are outlined, and a chapter is devoted to the origins and philosophy of Alcoholics Anonymous. Although AA is described by the authors as the most effective mass approach to alcoholism to date, at the same time they raise certain pertinent questions as to the modus operandi of AA, and its future development. In particular they emphasize that AA is not interested in the etiology and prevention of alcoholism, nor in helping those alcoholics who for one reason or another are unable to accept the AA program. As the authors phrase it, AA is really not interested in alcoholics in general, but only as they relate to AA itself.

It seems to this reviewer that many of these points have been refuted in the AA publication "Alcoholics Anonymous Comes of Age", in which the founder of AA states for example, "It would be a sorry day for AA if we ever came to think that we had a monoply on fixing drunks!" The writer consider that this statement more aptly characterizes the current attitude of AA towards other rehabilitative efforts on behalf of alcoholics.

The authors conclude with a survey of primary, secondary, and tertiary methods of prevention of alcoholism, pointing out that if an improved level of mental health generally were to be achieved in our society, the problem of alcoholism could probably be prevented. They also stress the desirability of integrating the use of alcohol into social customs in a matter-of-fact way, and the importance of the early detection of the potential or incipient alcoholic. The appendix contains an interesting and instructive series of case histories, and a comprehensive bibliography.

This is a book which is highly recommended for both the beginning and the advanced student of alcoholism, particularly for professional persons engaged in either educational activities about alcoholism or therapeutic work with alcoholic patients, and for the interested layman.

NCARP PROGRAM REVIEW
1961 - 1962
TREATMENT - EDUCATION

D. E. MacDonald, M.D.
Medical Director

N. L. Kelly, Ph.D.
Associate Director

TO write of the developments in the treatment program of the North Carolina Alcoholic Rehabilitation Center during the past year may give to the unwary reader an erroneous impression of certainty regarding certain aspects of alcoholism where none in reality exists.

It should be borne in mind that in our present state of knowledge the causes of alcoholism are ill-understood at best and its treatment in consequence is largely non-specific. In our group sessions at the Center, therefore, we discuss the various factors which contribute to the development of alcoholism, including the pharmacological actions of alcohol, cultural attitudes and social customs in their relationship to the use of alcohol, personality structure and its development, and the various treatment resources available to alcoholics in the State of North Carolina.

Acknowledgement is made, with thanks and gratitude, to Dr. Norbert Kelly and Mr. George Adams of the educational office for their contributions to the psychotherapy program and also to our many friends in A. A. who have travelled considerable distances to conduct meetings for the patients at the Center.

In attempting to elucidate the problem of alcoholism, I believe we are on the threshold of a breakthrough in understanding compar-

IN reviewing the principal developments in alcoholism education and community organization during the past year, two significant impressions stand out.

The first is that of heightened activity on both state and community levels. The number of local programs on alcoholism continued to increase until North Carolina now has sixteen. At the year's end five additional programs were in some stage of development.

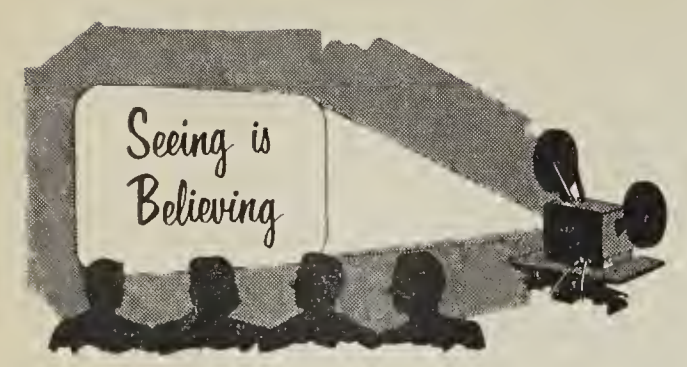
Not only did the number of community programs increase, but it is clearly evident that the existant programs expanded and deepened their activities.

Along with this heightening and expanding trend in education went increased agency cooperation and collaboration. A large step toward a concerted attack on alcoholism was evident in the cooperative efforts of the organizations comprising the local programs, the Department of Health Education, School of Public Health, University of North Carolina, and the North Carolina Alcoholic Rehabilitation Program. In selected activities, the National Institute of Mental Health provided additional scope to the developing cooperation and coordination in North Carolina.

These combined efforts, including their mutually valuable joint thinking planning and organizing phases, will be continued into the current

Continued on page 18

. . . through the Mass Media . . . Films . . . . T

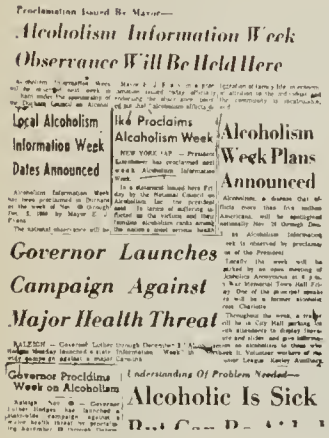


NCARP Films at Film Library State Board of Health

—841 Film Showings

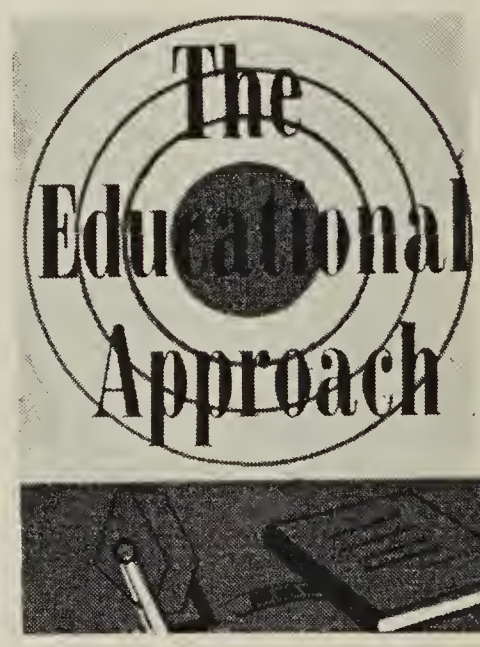
Seven Specialized Television Slides

Tal


Proclamation Issued By Mayor—
Alcoholism Information Week Observance Will Be Held Here
Local Alcoholism Information Week Dates Announced
Governor Launches Campaign Against Major Health Threat
Governor Proclaims Week on Alcoholism
Ike Proclaims Alcoholism Week
Alcoholism Week Plans Announced
Understanding Of Problem Needed—
Alcoholic Is Sick

Seven News Releases to 190 Newspapers

Six Sets Radio Spot Announcements (Six Spots Per Set) To 154 Radio Stations



Alcc

Program Planning Consultation With Local Alcohoilsm Programs— 19 Sessions

Planning and Participating in Educati Training Programs, Workshops and I

In Cooperation with Other Organizations:

25 Sessions including—

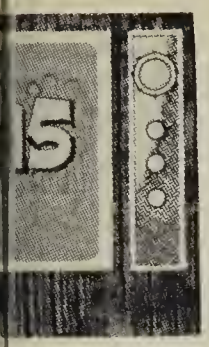
Mental Health
Teachers
Negro Groups
A. A.
Nurses
Flynn Houses
Churches
Parole Supervisors
Prisons
Industry

Other Activities:

1. **Participated in eight state, regional and national meetings and conferences on alcoholism.**
2. **Held reunion for ex-patients of the N. C. Alcoholic Rehabilitation Center and their families.**
3. **Provided opportunity for individuals and groups to visit the Center for training and observation of the treatment program.**

. . . through Program Planning . . . Educational & Training Pro

s . . . **Audio Visual Aids** . . .

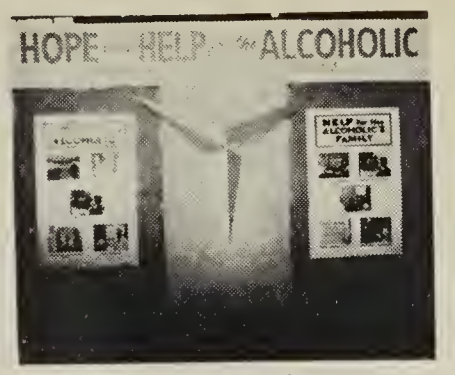


State Fair

N. C. Education Association

N. C. Medical Society

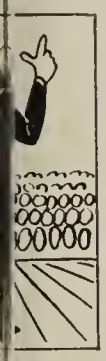
N. C. Mental Health Association



Exhibits

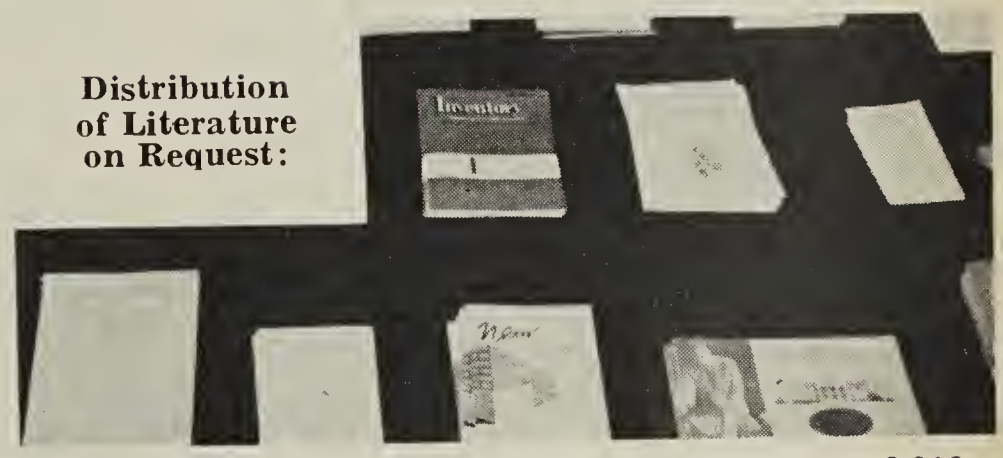
Participation in National Alcoholism Information Week

nd Informal Discussions on Request:



Church Groups
Nurses
Civic Clubs
P. T. A.'S
Ministers
Practical Nurses
Teachers
A. A. & Al-Anon

Distribution of Literature on Request:



Pamphlets & Brochures—30,811 / Inventory—118,816

ighlighting . . .

Activities of the NORTH CAROLINA blic Rehabilitation Program

July 1, 1961 - June 30, 1962

Conducting Special Credited Summer School Courses for Graduate & Student Teachers and Health Education Students:

East Carolina College
Catawba College
North Carolina College
Health Education Department
School of Public Health
University of North Carolina

l and
itutes

In Cooperation With Local Alcoholism Programs:

18 Sessions including—

P. T. A.'S
Businessmen
Churches
Teachers
Civic Clubs
Psychiatrists
Police Officers
Case Workers
The Public

Participation in Formal Student Training Programs:

Graduate & Student Nurses
Dorothea Dix Hospital

Health Education Students
University of North Carolina

Ministerial Students
Shaw University

Student Orientation
St. Andrews
Presbyterian College

Consultation with Colleges & Universities:

St. Andrews
Presbyterian College

Health Education Dept.
School of Public Health
University
of North Carolina

School of Social Work
University
of North Carolina

Department of Sociology
Duke University

gams . . . Lectures . . . Consultation . . . Summer Schools . . .

TREATMENT

CONTINUED FROM PAGE 15

able to that which occurred in the field of clinical psychiatry in 1911 when Dr. Eugene Bleuler designated the illness of Dementia Praecox by its new title, "the schizophrenias". I should like to suggest that we think not of "alcoholism" as though it were a static entity, but of "the alcoholisms", thereby indicating that there may be different forms of the illness arising from different causes, running different courses and requiring different forms of treatment. It is the failure to take this into account which leads to our present unsatisfactory definitions of alcoholism, and to the conflicting claims of therapeutic success with alcoholic patients which proponents of various treatment methods present. We need to ask "Which type of alcoholism?" and "Which type of alcoholic?" before we can assess the significance of such claims.

It is to be hoped that through our work at the Center we shall be able to contribute to a greater understanding of this baffling illness.

EDUCATION

CONTINUED FROM PAGE 15

year—and beyond, we hope. In our attack on alcoholism we are developing a formula for combining skills, experience, intelligence, and point of view. Working together, the several agencies are much more effective and can accomplish much more than can any unilateral effort.

When we develop an adquate program of activity evaluation to accompany joint endeavor, still another advance will have taken place. Our thoughts are turning in this direction for the coming year.

North Carolina Alcoholic Rehabilitation Center, Butner, N. C.

Facts About the ARC Patients - - Fiscal Year 1961-1962

Admissions by County Referred by Local Alcoholism Programs	
Buncombe	25
Catawba	13
Craven	6
Durham	11
Forsyth	25
Guilford	74
Mecklenburg	62
Moore	8
New Hanover	8
Orange	9
Rockingham	7
Rowan	8
Scotland	6
Vance	7
Wayne	4
Total	283

The majority of patients are referred by ministers, doctors and other professional persons. Few patients come on their own self referrals or by family referrals.

Occupations and Employment Status of Patients

Unemployed		Highest Occupational Categories
ARC Patients	23%	Salesmen
National Average	6%	Housewives

64% of the patients' wives were also employed.

Seasonal Admissions by Occupations	
Auto Salesmen	Dec., Jan., Feb. & March
Farmers	Oct., Nov., Dec. & Spring in Bad Weather
Construction Workers	When Weather Is Bad & Winter

Number Patients Admitted to ARC in 1961-1962

Marital Status	
Single	54
Married	373
Separated	81
Widowed	22
Divorced	72
Total	602

Age Groups	
Under 20	6
35-49	362
Over 65	10
Others	224
Total	602

More re-admissions than 1st admissions completed high school.

S E X	
Male	506
Female	96
Total	602

Types of Admissions	
1st Admissions	483
Re-Admissions	119
Total	602

Some Friends of Ours

By THOMAS JONES, M.D.

CHAIRMAN, DURHAM COUNCIL
ON ALCOHOLISM

A North Carolina physician points out that community fellowship and a sense of belonging can help the alcoholic find new faith in himself.

This speech, reprinted by permission of the author, was delivered at the Clergymen's Conference on Alcoholism which was held at the Iliff School of Theology at the University of Denver in Colorado October 16-18, 1961. It was originally published in a report of the proceedings of the conference under the title "Alcoholism—What Is It and Why Are We Here?"

SOME friends and neighbors of ours drink too much, too often, and for too long a stretch at a time. These friends may go for a period of time without touching a drop and then, suddenly, one drink taken for relaxation from some disagreeable tension starts the cycle all over again. It seems that the first drink inevitably calls for another, and another, and then another, until they are completely and suddenly drunk. It does not stop here, either, for day after day, night after long night, the drinking keeps up until something gives "way." It is either pocketbook, source of supply, patience of other members of the family, or else the sickness becomes so severe they just can't seem to keep any drink down. Several of them have lost their jobs. Others have gone broke. Many have given up their usual social life, and only a few seem to have any friends any more.

Worst of all, two or three of them don't seem normal when we meet on the street and talk. Their attention wanders; they have forgotten things that anybody ought to remember. Most of them have been to doctors a lot, and often one or another of them is in the hospital for a few days to get straightened out again. I know of two who have been away to institutions for long periods of time, but it seems that nothing helps for very long before the same trouble starts all over again. One man down at the end house in the block died last year. The paper said he was found dead in bed one morning, and the coroner

said it was due to natural causes. But we all knew that the cause was that he just naturally drank himself to death.

In the foregoing paragraphs, you have read the familiar account that could characterize almost any neighborhood in the country. Alcoholism is a frequent cause of chronic and acute illness, and is found in more homes among us than we like to admit. Statistics vary, but a few will remind us of the distressing frequency that makes it impossible to ignore its effect upon us all.

Important Statistics

Out of any average hundred adults over the age of eighteen, about seventy will drink alcoholic beverages at some time, and to some degree. About six out of the hundred will have difficulty of sorts, or problems of more or less serious nature resulting from this drinking, and two or three of the hundred will have reached that mysterious and forbidding point in their drinking pattern that they have a compulsion to drink, cannot take one drink without drinking more and more to a state of sickness or oblivion, and, unless something is done with them or for them, they will inevitably end up in premature death or insanity.

The six per cent who have problems with their drinking, or whose drinking results in serious problems, are fittingly called "problem drinkers." The two or three per cent who are excessive drinkers, compulsive drinkers, who have completely lost control of their drinking, are called the "alcoholics."

Statistics again tell us that approximately one out of every ten or twelve persons who drink with any pattern or regularity eventually become alcoholic. Again, there are about five million alcoholics estimated to be in this country. We see them often, but we see only a small fraction of them, for the larger bulk of alcoholics show only in their immediate surroundings—in absence from jobs, in hospitals, admitted by their doctors under misrepresentative diagnoses, or in the intimacy of their homes where we are called professionally to be of some service in times of distress.

There are many definitions of the alcoholic, or of the word, alcoholism. A complete one tells us that alcoholism is manifest in excessive drinking in the individual whose dependence on alcohol has reached such a degree that he shows noticeable mental disturbance, some interference with physical and mental health, interference with interpersonal relationships and/or interference with smooth social, domestic and economic functioning.

A shorter, but similar, definition expresses it this way: Alcoholism is the disease suffered by the man who drinks to the excess that his life is clearly hurt emotionally, he is rejected socially and damaged physically.

Other brief definitions state that the alcoholic drinks with increasing loss of rational self-control, or, the alcoholic is one who drinks to excess in deviation from the norm of his social group. Still another suggests that the alcoholic is a deviant from the social norm in his drinking pattern. He shows lack of self-control, and eventually manifests the destructive results of his excessive drinking in the social, psychological, physical and spiritual spheres.

The definition that has suited me best through the years, and which has given itself best to the interpretation of any situation, is this: Alcoholism is revealed in him who drinks to excess because he needs a power greater than himself.

No definition of alcoholism is com-

plete, however, without one additional explanation. Somewhere along the line of excessive drinking, there is a poorly understood, and ill-defined passable barrier, but it is passable in only one direction. On this side of that barrier the drinker presumably can stem the progress of his drinking by choice, or by change of pattern to a less excessive one. Or circumstances may change in his life where new conditions permit or alter his course where drinking is less desirable, and less practiced. Normal, acceptable social drinking may be his pattern then, indefinitely. However, if he passes this barrier, there is no return. From that time on, no matter what the mode of living or the self-determination exerted by that individual, he now has the irresistible compulsion that characterizes alcohol addiction; he is a dipsomaniac, a spree or binge drinker, a periodic or habitual alcoholic.

We do not know the changes that have taken place in his organic functioning or body economy. We cannot predict nor measure the alterations in cell function by any known laboratory tests. We only know that this does happen, and those to whom it has happened know it more certainly, and with more terrible horror, than anyone could possibly understand.

A favorite story of mine concerns a father on the occasion of his golden wedding anniversary. His sons wished to drink a champagne toast with him, but he casually protested he would drink a soft drink only, reminding them that over twenty years before he had been constantly plagued by habitual, compulsive alcoholic excess, and that he had maintained his sobriety only through deep faith and a determination never to touch alcoholic beverage again. His sons overpersuaded him, saying it had been so long, no trouble could ensue, and over the father's protests, he was persuaded to share the toast with them. The terrible, compulsive craving began at once, and he disappeared that day to be found three weeks later suffering from the effects of a prolonged spree.

It was quite a shock to me one day to have a wife call me to dress me down for having started her husband on a drinking bout. It was true that I had given him a prescription for a palatable tonic a few days before—a tonic I was accustomed to prescribing because of the uniform good results it appeared to have—but this mixture was carried in a wine base, and by the time the husband had taken his first few doses, he was stricken by an uncontrollable desire to drink, and the bout was well started by midnight of that same day. I have heard enough from proven and self-confessed alcoholics through the years to appreciate the validity of this point.

In a prison recreation room one night, I asked a group of fifteen if they would take a small drink if I would place it before each one. Fourteen shook their heads, each saying the same thing in his own words, "If I can't get more right away afterwards, I sure won't take that first one." Each recognized the vulnerability to the compulsive craving that always started with the first drink. I asked the fifteenth why he would take his drink, and he slyly told me later that he wouldn't mind it for he had a new fifth of whiskey hidden behind a fence post in the prison yard. So much for the reality of the compulsive, irresistible craving for continued drinking that comes to the alcoholic who takes his first drink.

That indefinable change that has taken place in the make-up of the alcoholic is real, no matter how we look at it, no matter how little we know of its validity. The alcoholic does have a real problem, a medical problem, for its existence is well-known to any and all who deal constantly with him in his distress. He doesn't want to be that way. He no more wants that situation than the diabetic wants the inability to utilize sweets, or than the epileptic wants convulsions. After the first drink, his course is as predictable as a rudderless ship in a hurricane. He is driven relentlessly by the terrible storm of his desire. It is in this compulsive period that men and women commit the acts of deviation or assault that fill our magistrates' courts and prison camps.

At times, this compulsive desire may come with overwhelming force before the first drink is taken. Then it seems to be entirely a psychologic need rather than a physiologic one, yet those who admit of this vulnerability freely acknowledge that the driving thirst is just as great, just as terrible, in its compulsive nature.

Alcoholism: An Addiction

Alcoholism truly is bottled bondage. It is addictive in every sense of the word. It may be the allergy to alcohol that has developed; it may be due to chemical disturbance, nutritional defect, disturbance of some intrinsic cellular metabolism, or any other situation you may envision, but it does exist; it is real; it is irresistible to the alcoholic; and we who are so fortunate as to be exempt from this compulsion can well say, "But for the grace of God, that could be me."

Much more could be added to these statements about alcoholics and alcoholism, but additional facts with some unusual exceptions to the general pattern would serve only to confuse or cloud these basic truths about the situation.

The practical reality is that people drink, some drink to excess, some develop alcoholism. Drunkenness does not necessarily signify alcoholism, and there are many alcoholics near and about today who have not taken a drink for years and years. Many heavy social and controlled

drinkers may drink far more in amount than many a seriously affected alcoholic.

It is curious that in cultures which approve and allow drinking as part of the daily habit pattern there are found few alcoholics. By other curious contrast, some of the most difficult alcoholics, resistant more than most to approach and treatment, come from cultures that forbid most emphatically any use of intoxicants.

Within the past decade the American Medical Association has passed a resolution that alcoholism is an illness and can be treated. Churches of many denominations have developed serious programs dealing with the alcoholic, seeking understanding of his problems, accepting in principle to greater or lesser degree that his compulsive drinking may or does stem from changes within him beyond his control. While some churches teach that drinking is a sin, that he who drinks is a sinner, it is only recently that a new look has been taken at the problem. With it is coming the realization that the alcoholic should be considered actually sick, rather than condemned; that pastoral counseling should be developed in such ways that the alcoholic would freely seek spiritual guidance, and that the church should be as available to the alcoholic in his need for worship and for salvation as to the non-alcoholic.

I ask your indulgence in repeating the definition for alcoholism that I said suited my purposes and needs best, for I do wish to make a statement that has apparently arisen from better understanding of that particular definition as the years have passed and I have used it more and more frequently.

Alcoholism is revealed in him who drinks to excess because he needs a power greater than himself.

The alcoholic is a sensitive person. Even when drunk and his sensibilities are dulled, his sensitivity is not. Most sensitive of all is he to the sense of guilt he feels because of his state. This emotional anguish is reflected in the extremity of the remorse he has and reveals in word and action. This is found in no other illness nor diseased state to the degree that it is found in the alcoholic.

It is agreed that he is physically sick, as shown by the recount of various distresses and physical impairments revealed by examination. He is emotionally sick, as we know by his terrible sense of loneliness, his feeling of guilt and remorse, his conviction of personal inadequacy and need for help.

Spiritually Sick

He is spiritually sick, too, as he professes his separation from spiritual influence and help. As with us all, he receives help and consolation, with forgiveness, in proportion to his sense of need. It is only with complete surrender in his helplessness of addiction that he begins anew his awareness of need for surrender to the will and care of a higher power. This is very, very important, and very, very real to him. And herein lies my conviction about this aspect of the alcoholic's sickness.

The spiritual sickness that he feels and manifests so starkly is the desperate loneliness of a man who suddenly is conscious of his separation from God as he has always known Him. I honestly think that the alcoholic is by his very nature more conscious of his kinship with his heavenly Father. I believe he is more sincere than most non-alcoholics when he expresses his abject fear that God has forgotten him, no longer cares. I further believe that when he expresses his deep desire to turn his will and his life over to the care of God as he knows Him, that he

feels the sincerity of this conviction to a far deeper degree than can be properly assessed.

We understand so little of this relationship. We are limited by our capacity for faith. But the alcoholic, who is sensitive to emotional suffering, who cannot endure psychic distress, has found in the bottle a means of early oblivion that these feelings can no longer plague him. Thus, he suffers his remorse to a greater degree afterward, for deep within himself, he knows he has run from his heavenly Father. He has dived into the bottle to drown out the inner voice that says, "Come to me." No other self-imposed anaesthesia works so well nor so destructively as alcohol. Only in a state of unconsciousness or oblivion can God be entirely shut out. This the alcoholic has done. But his guilt is greater in his own eyes for having done so.

By the same token, when complete surrender to God as he understands Him is made, his conversion is more complete, his devotion in faith is deeper, and his life so often manifests afterward a willingness to confess God before men that few others are willing to do. I believe that because he is so conscious of his origins in God, his suffering when he is so lost, so horribly lost, that the temporary suicide of drunkenness is but a way out of his confusion and dilemma. Because he has suffered so much, he can achieve so much after he does surrender to a higher power. For this reason alone, I would give him high priority in personal ministry to help him with his spiritual sickness.

Perhaps I have belabored that conviction too much for the purposes of this meeting. Workshops on alcoholism are concerned with education. Intelligent approach to the various aspects of this area of concern make for alertness to the many tangents, angles, pitfalls and other complexities that lead the newcomer astray, or leave him dangling from one philosophy or so-called scientific generalization. Many of us are guilty of assuming that there is a neat set of reasons for the cause of alcoholism, another for diagnostic criteria, and still another set of specifics in the area of treatment. Nothing could be further from the truth. There is no known uniformity of personality defect that predisposes to the development of this disease. Many and contrasting beliefs are held.

Variety of Opinions

There are those who believe that hereditary taint is suspect. Others hold for physiochemical imbalance, while nutritional defects, either inherited or acquired, may be blamed. Vitamin deficiency is found in many alcoholics, as is faulty sugar metabolism or peculiarities of liver function. However, many believe that such findings are the result, rather than possible cause, of alcoholism. Abstinent parents may beget alcoholic children, and alcoholic parents may procreate abstinent children of high intelligence and outstanding performance in the world. Hormonal imbalance has also been blamed for alcoholism, as has faulty or poorly controlled function of the thalamus, a portion of the brain. Recent developments in complex and hitherto unknown effects of certain chemicals upon the emotional control and behavior pattern of certain susceptible individuals may be relevant to a possible predisposing vulnerability to alcoholism in certain individuals, but this is still largely theory, and cannot be accepted so far as being pertinent.

It is our purpose here today to accept the fact that out of many who drink, a certain number are to be found who cannot drink with con-

trol, and who ultimately develop the disease called alcoholism. This one fact is common to all alcoholics—they cannot drink with control. Another fact is that, untreated, alcoholism ultimately ends in early or untimely death, or in insanity.

Another accepted fact is that most alcoholics ultimately reveal strikingly similar emotional extravagances. There is a high level of anxiety in interpersonal relationships, emotional immaturity is usually present, and there is a low tolerance for frustration. Often there is lowered self-esteem, even in individuals obviously high on the ladder of attainment in their chosen role in life. The alcoholic usually feels a sense of loneliness and isolation, and guilt feelings plague him, usually without his being aware of the cause. Perfectionism drives the alcoholic relentlessly, even far beyond the goals set for him, for he sets goals for himself usually too high for human attainment—hence the perpetual failure. Compulsion and impetuosity characterize most of his actions, except where fear and difficulty in the interpersonal relationships make for the frustration again.

Most alcoholics tell me that what they most want from people generally is to be treated as a human being. Therein lies a tragedy, for by their behavior at home, at work, in organizations, their addiction causes such adverse reactions in family life, at their place of business, and in most all other points of contact, that they gradually lose the very right they would cherish.

The average man or woman is going to react to the alcoholic with one main response; they simply want to have nothing to do with him. Rejection comes early and proceeds with the equivalent speed that the alcoholic winds his way down towards his own personal depths. If they went to this finality of destruction without disturbing the world they left behind, it is doubtful if any but the most sacrificial and dedicated would pay them much more than sorrowful good-bye, if even that much. However, they create and leave burden after burden along the way, disturb so many areas of usually placid existence, and by the very care that must be expended in their behalf, their very presence in the world influences and gives temporary or lasting distress to so many that the cry of the times is, "Something must be done."

Miracle of Recovery

That alcoholics too, are God's children, imposes thought for their care upon all those in the behavioral sciences, and more especially upon those who find in them something precious, something of intrinsic worth, that must be salvaged at all costs. There is nothing more rewarding to any of us than to participate in the miracle of recovery that is ever possible in the most desperate alcoholic. Alcoholics Anonymous was founded on the discovery that hopeless alcoholics could and did recover. There was no cure in the sense of the absolute, that he might drink safely again as the so-called normal person could. But he could recover his sanity, his health and his return to normal living just so long as he did not take a drink. Here was a goal.

The Twelve Steps and the Twelve Traditions of AA were evolved as suggested steps whereby this recovery might be achieved. Nearly three decades have gone by since the early meetings, but it has amply been proved that this was to date the best and most dependable means of recovery. Such miracles have taken place in the history of A. A. that

(Continued on page 31)

The Doctor's Responsibility

In life I was the town drunkard;
When I died the priest denied me burial
In holy ground.
The which redounded to my good
fortune.
For the Protestants bought this lot,
And buried my body here,
Close to the grave of the banker
Nicholas,
And of his wife Priscilla.
Take note, ye prudent and pious souls,
Of the cross-currents in life
Which bring honor to the dead,
Who lived in shame.

Edgar Lee Masters,
Spoon River Anthology

If the medical profession will disabuse itself of the idea that alcoholism is a behavior problem scarcely worthy of attention, the opportunities for treatment will become apparent. No field of medicine offers a greater challenge, since none has been so long neglected, and perhaps in no other are there as many kinds of satisfaction.

Methods helpful to the general physician are described, as well as some pitfalls. The medical profession brings a variety of assets to this work, and more participation in it is both needed and logical. Social turmoil is the womb of illness, and no form of deviant behavior is more socially destructive than alcoholism.

—From Postgraduate Medicine

to an Alcoholic

By ARCHIBALD L. RUPRECHT, M.D.

FIRST of A THREE-PART SERIES

DESPITE a growing interest in most aspects of alcoholism, many physicians remain inactive in this field. In small towns, where alcoholics are hard to ignore, doctors usually feel responsibility for these patients, but the more urban physicians often regard this disease as simply a behavior problem and not their concern. Some accept alcoholism as a recurring illness like bronchial asthma but practice only first aid by treating just malnutrition and withdrawal

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states. Few practitioners make a genuine effort to help alcoholics stop the progression of their disease in its early stages or rehabilitate themselves in later stages. This is the doctor's role in alcoholism as in other entities.

A physician's reluctance to treat alcoholics is usually a mixture of ignorance and despair for a recovery. Rarely do medical schools teach a useful approach to these patients or even that rehabilitation is possible. Hospital training often exposes doctors only to the acute ailments that punctuate chronic inebriety, a situation like that of treating pain without a chance to treat the cause. Yet alcoholism afflicts about 5,000,000 people and is the fourth most common disease in the United States. Prevalence is not the sole concern, since persons are often affected in their most productive years and the disease causes marked social damage in homes. Even if emphasis is only on physical aspects, no other illness can lead to the variety of major lesions that may occur in every system of the body.

Despite these compelling facts, doctors err and think the stir is over the homeless and destitute who in reality comprise less than 10 percent of the alcoholic population. Little can be expected of persons who seem socially and physically bankrupt (though surprises occur), but this need not cloud the outlook for the majority, for those patients in any practice whose alcoholism may be obvious, newly apparent or still hidden. History taking for alcoholism is a separate topic worthy of another paper. The aim here is to outline a doctor's responsibility to an alcoholic by means of a tentative list of ways to help him; emphasis is on material of use to the general physician.

The Definition of Alcoholism

Of prime importance to doctor and patient is how best to define alcoholism. Society tolerates so wide a range of drinking behavior that people find it hard to examine their own objectively. For office use, a good definition of alcoholism is that of the World Health Organization: drinking that interferes with health, work or personal relations at home. This description startles some patients and can provoke as much reflection as a first bout of hallucinosis. Much good is done by citing this definition early in the disease before the drinker

evolves a denial system. As a helpful and neutral authority, the doctor is in the best position to do this; and if he talks to someone headed for later stages of the illness, there may never be a better opportunity. The shame attached to alcoholism is rightly deplored, but it can be evoked indirectly to alert and motivate patients. If the definition alarms, the only comfort is that alcoholism attacks without any regard to either ability or social status.

Once it is realized by both patient and physician that the definition fits, the physician avoids making light of the patient's difficulty with alcohol. Heavy drinkers often rationalize their intake, whereas a doctor needs to maintain their concern about the diagnosis. The significance of even early alcoholism is blunted by failure to require periodic office visits or in some way to show a helpful interest. Words are not minced in these contacts, care being taken to avoid asking shyly about recent drinking or speaking only indirectly of alcoholism.

There is little place in the office management of alcoholism for a division of cases into "problem drinkers" and "alcoholics" based on whether or not control of drinking has been lost. "Problem drinking" is a good term with which to explore drinking habits, but beyond that it easily becomes a euphemism. Too often, alcoholics adjust their notion of control to keep pace with heavier intake.

If a man or woman questions being alcoholic without blatant loss of control, the doctor explains that this starts when the amount drunk exceeds intent a majority of times. If the drinking affects the health-job-home triad, any physician using a milder word than alcoholism joins the too-full ranks of those who baby the patient. A warning, too, about dividing alcoholics into types such as primary or true and secondary or symptomatic: This can help some patients deny the gravity or forget the potential of their drinking behavior. These may be useful categories for research, but patients remember the adjectives and forget the noun they modify. In the consulting room there is only one alcoholism, an insidious and usually progressive illness.

The Best Attitude of a Doctor

Early in his contact with all types of alcoholics, a doctor needs to show a warm and accepting attitude. In most instances the patient has had a deprived childhood, with parental rejection a major feature. Friendliness from the physician is essential if a helpful relation is to begin. This cannot be stressed too much, since the shame of heavy drinking heightens the sense of being unworthy of attention from a parent substitute. In extreme cases, alcoholism may be viewed as a spurning of society by the drinker; the doctor does well to behave as thoughtfully as if coming upon a recluse. Inebriates are hair-sensitive to behavior toward them which they can interpret as rejecting and test their physicians early and repeatedly.

The best time to show acceptance is on the occasion of meeting the patient, regardless of whether or not he asks directly for your view. Alcoholics muster nerve to request care, and there is no better time to encourage and motivate them toward further help. A few words can allay the fear of rejection. "It's not as easy to stop drinking as some think" is one good opening. A neutral attitude is also shown by "Alcoholics suffer more than many people with other diseases." Still another variant is "I don't believe anybody really enjoys

heavy drinking; it creates more problems than it solves," providing a chance for the patient to talk.

A chance to converse is a part of acceptance, too, but may be difficult initially due to withdrawal symptoms or acute intoxication. If so, proper medical care, an unhurried manner, and a word about a wish to help will suffice. At least thirty minutes should be spent with the less acutely ill alcoholic being interviewed for the first time. Although it is not practical generally to attempt a history or psychotherapy with patients impaired by recent drinking, the first meeting or two is a proper exception. The patient may vent anger or other emotion and provide material for future use; if not, at least the inebriate can feel this is someone willing to accept him as he is. Sobriety is advised for later interviews, explaining that a clear head thinks and remembers best.

To be deplored is a hasty vitamin injection with the admonition to stop drinking. This shows that you begrudge the alcoholic time and do not realize how frequently he has said as much to himself. Were it so easy, he would not ask for help. Doctors may understand better the problem of an alcoholic if they can contemplate in their own behavior a repetitive act they regret but do not avoid. Drunkenness does require alcohol, but so much more is involved that the physician must not let a reaction to drinking behavior raise a barrier between himself and the patient. Even later, when sobriety is abruptly broken, a remark about learning to tolerate anxiety or resentment is many times more helpful than a critical remark about the drinking itself, which puts one on the side of nagging relatives and also reveals the mistake of reacting personally.

Apropos of breaks in sobriety, requests for house calls to treat withdrawal should be handled selectively. An alcoholic whom the doctor has never seen merits a visit to the home at any hour requested; this may be when the patient can admit he needs help and will use advice. Perhaps also the patient's experience with other physicians has been maddening. The first call to a doctor can be a turning point, and the physician should go with this in mind. Further, the physical state of a strange patient cannot be judged except directly.

Patient-Doctor Relationship

The same holds for an alcoholic who makes some gains but drops from view until he calls again after a serious break in sobriety. Here is a chance for patient and doctor to examine the precipitating event and build their relation by helping the drinker over his newly aggravated sense of shame.

Quite different are repeated odd-hour calls from alcoholics making scant effort to control their drinking. Parenthetically, these are the bane of the busy doctor's life, but only until he educates his patients. When it is a case of simple alcohol withdrawal, the doctor helps most by saying with composure that coming to the home would merely make further drinking and self-destruction easier. Only if he refuses to be manipulated can the doctor divert the patient from satisfying his dependent needs in this fashion. To avoid rejection, a night's sedation is ordered from the drugstore (if one is open) and the patient is asked to come to the office the next day. If the inebriate objects, a good rejoinder is to regret he feels that way but that the first-aid approach to alcoholism is ineffective and you wish to protect him from it. Relatives who demand a house call for this type of

patient are best dealt with similarly.

Whether or not to hospitalize for withdrawal is another decision the doctor must make frequently. Patients in delirium tremens require hospitalization, but many less gravely ill can be treated as outpatients. Examples are those suffering from the tremulous state, dehydration, alcoholic gastritis and even mild hallucinosis. Day care is adequate for these entities, the patient coming to the office with a relative on several successive days and being given dextrose and saline infusions, an antacid and sedation. To this third person, often the spouse, is given the job of accompanying the drinker home and back and giving pills as directed until the patient is well enough to be trusted.

Although this outpatient treatment is less expensive than hospital care, the money saved is not the major gain. Pressure to hospitalize can be greatest from a wife or mother seeking the temporary triumph of getting the alcoholic out of the house. Yielding to this pressure may interfere with teaching these persons their role in recovery: several daily office contacts with the doctor can help orient them. Key relatives will usually assist the acutely ill alcoholic but often refuse to come for an interview once that phase is over.

The outpatient approach serves a drinker's interest in other ways. The desire to go to a hospital can be mostly a wish to lie down and be cared for, but office appointments may implant a new and healthier attitude, that of taking an active part in recovery. Release from a hospital usually implies recovery from illness; naturally, some alcoholics respond with a sense of cure and a denial of the need for help. When a doctor is forced to treat repeated bouts of withdrawal as episodic and severe enough to require going to bed, he may help keep some patients sick. Moreover, an accumulation of hospital bills for this type of care can be a form of passive aggression against a domineering wife who understandably has taken on the task of meeting family expenses. By being party to this, the doctor aggravates the problem and makes his own job harder. Some conditions in alcoholics do indeed merit bed care, and hospitals should liberalize criteria for admission of inebriates, but the act of hospitalizing is always a double-edged blade. How it cuts will vary. That the patient can afford or wants hospitalization is in itself a weak reason to sanction it.

Precautionary Measures

Hospital care is at times proposed to observe for sequelae of a drinking bout. Either a relative or the alcoholic himself fears epileptic seizures or delirium tremens. Symptoms of alcohol withdrawal are often similar in the same patient due to a pattern of drinking and bodily individuality. Some inebriates hardly ever retch, and others dread this the most. The history of previous withdrawal should always be taken carefully; this is reassuring to all parties and allows proper therapy. If abstinence has ever led to convulsions, giving Dilantin (diphenylhydantoin sodium) for a week is good prophylaxis. If "dry heaves" are usually a symptom, an antiemetic is advisable. Serious lesions such as aspiration pneumonia and esophageal rupture may thus be avoided. If the past history and length of the drinking bout favor delirium tremens, extra sedation should be given and the patient asked daily about nightmares, since these may be prodromal. The need for hospitalization may become less with these methods, but surely morbidity will decline and physical recovery will be quicker.

RESPONSIBILITIES

CONTINUED FROM PAGE 11

a full blown grand mal convulsion? Failures? Yes and no. The ways of learning of the human mind and the human soul are devious and in every conviction lies a finite, not to be ignored, shadow of doubt. So the diabetic restored to health immediately doubts that he was ever ill—he tries to ignore his disease and fails. So the patient with a convulsive disorder doubts his disease, ignores his treatment and rediscovers in his misery that he is ill.

Must we, then, expect the alcoholic to accept intellectually and emotionally without question that he is a sick man and turn his back unwaveringly and unfalteringly on his disease and march without a slip into full physical, physiological, and emotional health? This is hardly a realistic attitude.

Medicine has an obligation long ignored of coming to terms with the disease. Alcoholism, from a relatively unimportant, supposedly isolated problem; looked askance upon by religious and moral leaders; with disgust by society at large; with indulgence by family and friends; and, as a basis for humor and mirth by all; has become the Number One health problem of our day.

Thoughtful people who have dealt intimately with this aberration whether from necessity or through choice almost universally pronounce it a disease. As such, it is first of all a medical problem and a final solution will not be found except in the broad plane of scientific medicine. This is medicine's responsibility. That it will eventually be accepted and discharged, none will doubt. Many are irked by delay and apparent indifference. Logically and properly, the time to get on with the problem is now.

SOME FRIENDS OF OURS

CONTINUED FROM PAGE 25

thousands of others now have scrutinized these steps and traditions, and almost every organization in existence today that operates in this area of concern has intertwined in its organizational procedure some essence of them.

We have come a long way. Much work lies ahead. If I could express but one wish in reference to the future, it would be that the essence of treatment would be distilled in fellowship. Fellowship in A. A. could be matched by fellowship on the hospital ward, in the neighborhood, after hours in the judge's chambers or in the physician's offices. Fellowship gatherings are in existence in many business offices, in the armed services, in churches, in most large industries and in many small plants. Wherever there is fellowship, there is a sense of belonging, and of freedom from compulsive, destructive behavior. There is freedom in fellowship from bottled bondage.

And out of these fellowships emerges the new man, the new woman, freed from the shackles of a devastating disease. Basic dangers still exist, but through fellowship the new individual is learning how to cope with treacherous emotions; he is learning how to channel newly released energies into creative and productive enterprise; he is learning how to get along with people whom he formerly feared. But most important of all, he is acquiring a new faith in himself, a stronger love for his fellowman, and a greater faith in God.

In this area, ladies and gentlemen, we are all privileged to serve. May we rededicate ourselves to the greatest principle of all, that we love one another, and that includes the alcoholic.

Currently in North Carolina there are fourteen

LOCAL PROGRAMS ON ALCOHOLISM

Educating the public is one of the major functions of these community groups and the key to prevention of alcoholism.

ASHEVILLE—

Citizens' Committee on Alcoholism
SGT. CARROL R. OWENS, CHAIRMAN
Municipal Building, Asheville

Educational Division, Board of Alcohol Control, West Wing, Parkway Office Building
DON DANCY, EDUCATIONAL DIRECTOR
Phone: ALpine 3-7567

CHARLOTTE—

Charlotte Council on Alcoholism
1125 East Morehead Street
REV. JOSEPH KELLERMAN, DIRECTOR
WILLIAM HALES, ASSOCIATE DIRECTOR
Phone: FRanklin 5-5521

DURHAM—

Durham Council on Alcoholism
602 Snow Building
MRS. OLGA DAVIS, EXECUTIVE DIRECTOR — Phone: 682-5227

GOLDSBORO—

Wayne County Program on Alcoholism
P. O. Box 1320 — Phone: 734-0541
A. T. GRIFFIN, JR., EXECUTIVE DIRECTOR

GREENSBORO—

Greensboro Council on Alcoholism
216 W. Market St., Room 206 Irvin Arcade—Phone: 275-6471
WORTH WILLIAMS, EXECUTIVE DIRECTOR

HENDERSON—

Vance County Program on Alcoholism—Phone: GEneva 8-3274 or GEneva 8-4702
DR. J. N. NEEDHAM, DIRECTOR
2035 Raleigh Road

LAURINBURG

Scotland County Citizens Committee on Alcoholism
308 State Bank Building—
P. O. Box 1229
M. L. WALTERS, EXECUTIVE SECRETARY — Phone 276-2209

NEW BERN—

Craven County Council on Alcoholism, Inc.
409½ Broad Street—P. O. Box 1466
GRAY WHEELER, EXECUTIVE SECRETARY — Phone: 637-5719

NEWTON—

Educational Division, Catawba County ABC Board
REV. R. P. SIEVING, 130 Pinehurst Lane — Phone: INgersoll 4-3400

REIDSVILLE—

Rockingham County Committee on Alcoholism
225 West Morehead Street,
P. O. Box 355
MRS. ANNE WALL, EXECUTIVE SECRETARY—Phone: DIckens 9-4369

SALISBURY—

Educational Division Rowan County ABC Board, P. O. Box 114
PETER COOPER, DIRECTOR
Phone: 633-1641

SOUTHERN PINES—

Moore County Alcoholic Education Committee, P. O. Box 1098
REV. MARTIN CALDWELL, DIRECTOR
Phone: OXford 2-3171

WILMINGTON—

New Hanover County Council on Alcoholism, 316 Insurance Building
MRS. MARGARET DAVIS, EXECUTIVE SECRETARY

WINSTON-SALEM—

Alcoholism Program of Forsyth County
802 O'Hanlon Bldg., 105 W. 4th St.
MARSHALL C. ABEE, EXECUTIVE DIRECTOR — Phone: PArk 5-5359

OUT-PATIENT SERVICES

FOR

ALCOHOLICS AND THEIR FAMILIES

ARE PROVIDED BY THE FOLLOWING

MENTAL HEALTH FACILITIES

Competent Help Is Available At The Local Level

Mental Health Center of Western North Carolina, Inc.
415 City Hall
Asheville, N. C.
Phone: ALpine 4-2331

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
Chapel Hill, N. C.
Phone: 942-4131, Extension 336

Mental Health Center of Charlotte and Mecklenburg County, Inc.
1200 Blythe Blvd.
Charlotte 3, N. C.
Phone: FRanklin 5-8861

Cabarrus County Health Department
Concord, N. C.
Phone: STate 2-4121

Cleveland County Mental Health Clinic
409 East Marion St.
Shelby, N. C.

Cumberland County Guidance Center
Cape Fear Valley Hospital
Fayetteville, N. C.
Phone: HUdson 4-8123

Forsyth County Program On Alcoholism
802 O'Hanlon Bldg.,
105 W. 4th St.
Winston-Salem, N. C.
Phone: PArk 5-5359

Gaston County Health Department
Gastonia, N. C.
Phone: UNiversity 4-4331

Guilford County Mental Health Center
300 East Northwood Street
Greensboro, N. C.
Phone: BRoadway 3-9426

Guilford County Mental Health Center
936 Montlieu Avenue
High Point, N. C.
Phone: 9929

Pitt County Mental Health Clinic
Pitt County Health Department
P. O. Box 584
Greenville, N. C.
Phone: PLaza 2-7151

Dorothea Dix Alcoholic Rehabilitation Service and Out-Patient Clinic
South Boylan Ave., Raleigh, N. C.
Mrs. Dorothy Ferrell, Psychiatric Social worker—Phone: TEmple 2-7581; Ext. 421

Mental Health Center of Raleigh and Wake County, Inc.
615 Wills Forest Road
Raleigh, N. C.
Phone: TEmple 4-6484

Rowan County Mental Health Clinic
Community Building
Main and Council Streets
Salisbury, N. C.
Phone: MElrose 3-3616

Wilson County Mental Health Clinic
Encas Rural Station
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VOL. 12, NO. 4 NOV.-DEC., 1962

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

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Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

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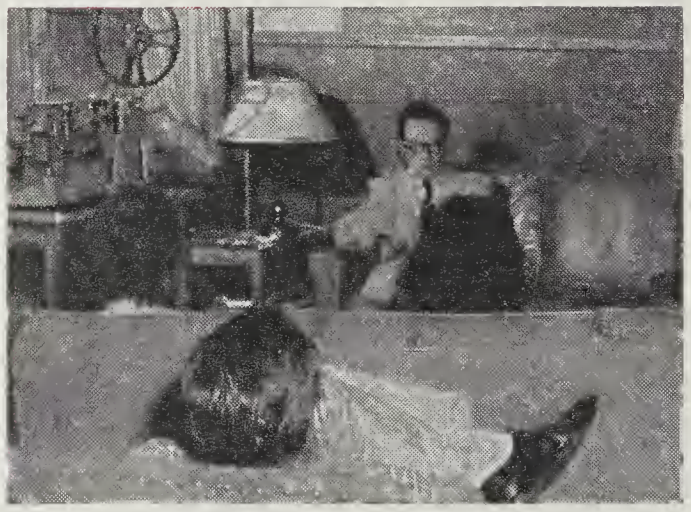
1. Admission is by appointment in response to written or telephone request to the Medical Director of the Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment. All appointments must be confirmed by mail.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Services Agency, and a complete medical history, compiled by the patient's family physician, are necessary.



3. A fee of $75, in cash or certified check, must be paid upon admission.

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It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

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Patients must be sober upon admission, and in good physical condition. Patients may have visitors after they've been at the Center for 2 weeks. Visiting hours are from 1:00 - 4:00 P.M. on Saturday and Sunday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

NORBERT L. KELLY, Ph.D.
Associate Director

NORMAN DESROSIERS, M.D.
Acting Medical Director

GEORGE H. ADAMS
Educational Director

INVENTORY

VOLUME 12 NUMBER 4

NOVEMBER-DECEMBER, 1962

RALEIGH, N. C.

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This journal is printed as a public information service. Persons desiring a place on the free mailing list must send in a written request, with the exception that *new* requests from *individuals* residing outside North Carolina can no longer be accepted. The views expressed in articles published in *Inventory* are those of the authors and not necessarily those of the NCARP. Manuscripts are invited with understanding that no fees can be paid.

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UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

ALCOHOLISM:

BY RICHARD H. WHITTEMORE
COUNSELOR
STATE OF MAINE
DIVISION OF
ALCOHOLIC REHABILITATION

THE prevalence of alcoholism in the state of Maine is high enough to warrant attention as a serious public health problem. Most every town or city of any size in Maine has its "skid row," slum area and "honkytonk joints," but these are not the cause, or always the end result of alcoholism, a disease that has no respect for persons, rich or poor, educated or underprivileged, men or women, young or old on every rung of our social structure.

"Alcoholics are those excessive drinkers whose dependence upon alcohol has attained such a degree that it shows a noticeable mental disturbance or an interference with their bodily or mental health, their interpersonal relations, and their smooth social and economic functioning; or who show the prodromal signs of such developments. They therefore require treatment." This definition was published by the World Health Organization, Alcoholism Sub-committee, in August, 1952.

Various titles have been used to refer to those who have abnormal drinking patterns: Excessive drinker; problem drinker; addictive drinker; uncontrolled drinker; and alcoholic. There are many attitudes about drinking, and each title projects a different mental picture, interpretation and attitude for each individual, depending upon his or her early training, experiences and relationships with "tee-totalers," "social drinkers" and "alcoholics", plus his or her personal experiences in the use of alcoholic beverages.

Dr. Seldon D. Bacon, Ph.D., Director of the former Yale Center on Alcohol Studies, now the Rutgers Center on Alcohol Studies, gives this non-technical definition of alcoholism: "Alcoholism is a medical and social disorder characterized by the uncontrolled use of alcohol and the progressive disorganization of the physical, psychological and environmental effectiveness of an individual."

Recent figures indicate, using the above definitions, that there are five million alcoholics (male and female adults) in the United States today. Using the same formula we arrive at approximately 27,000 in the state of Maine and the disease is still on the increase. If these figures referred to polio or smallpox we would be well aware of a serious epidemic. As far as we know alcoholism is not contagious, but alcoholism has been termed a disease by sociologists, psychologists and medical authorities.

Dr. Marvin A. Block, Chairman of the Committee on Alcoholism, American Medical Association Council on Mental Health, writes: "With the new positive approach to this public health problem, the physician treats these sufferers as sick people. He recognizes personality defects in those who react so unusually to alcohol. He knows that the problem drinker has an immaturely developed personality and uses alcohol to escape life's pressures and gain relief from the tensions which living often

A mature understanding of the illness of alcoholism, brought about through public education and information, can be an effective means of combating this serious public health problem.

a PUBLIC HEALTH PROBLEM

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entails. Such patients employ alcohol as a drug. For many years doctors have studied the physical and emotional characteristics of this illness. Much has been learned, but as with many other medical problems, the specific answer has not yet been found."

Causes of Alcoholism

Escape is sometimes over-emphasized when explaining the causes of alcoholism. Could the alcoholic not be seeking something else . . . sociability, excitement, romance, adventure? Perhaps it could be a spiritual search. On the other hand, a social drinker, who has nothing to escape from but enjoys the taste and effect of liquor, might become an alcoholic through continued, excessive use.

There is no positive way of identifying the "potential" alcoholic. If anxiety, fear, tension and personality conflicts alone cause alcoholism, then over half the population of this country would be alcoholic. It takes a combination of many factors to produce alcoholism. It is a *total disease* involving the whole person, mentally, physicially, socially, and spiritually.

The drinking of alcoholic beverages is socially and legally accepted in most parts of this country today. Therefore, most people take up drinking as an "accepted custom." They are not threatened with the possibility of becoming an alcoholic. This is always the least of their worries. The beginning is innocent enough. Smokers today can worry about cancer, but the drinker never worries about alcoholism. He doesn't worry about it even after problems begin to arise in connection with his (or her) drinking habits because the mental picture of the alcoholic is that of the "bum-on-skid-row" and no one wants to identify himself with this.

Causes? Who can say what the real causes are? They can be as many and as varied as there are alcoholics. There are, however, a few outstandingly noticeable symptoms: emotional immaturity; mental obsessions; physical compulsion, and an overactive conscience.

Most adverse situations can emotionally upset alcoholics to such an extent that they have to go out and

throw their tantrums by getting drunk. On the other hand, if they get a raise in pay, win a bet, or if the wife has a baby, they must celebrate by drinking. (Usually, but not always intentionally, they get drunk.) They use liquor as a panacea as well as a narcotic.

The alcoholic has obsessions that drinking improves his personality; that he is a more interesting, intelligent and productive person "with a few drinks aboard." He usually feels dull and bored when sober. He believes he cannot have any fun at a social function until he is "feeling high." The alcoholic does not drink to find the courage to perform immoral or illegal acts. He might, however, perform such acts while under the influence because of reduced controls.

We find that most alcoholics have a physical compulsion . . . a hunger, a thirst for more and more alcohol after they have taken the first drink. In some instances it could be a psychological desire to soothe a physiological pain . . . "raw nerves." It could be just the desire to hold onto a "warm, comfortable feeling." This craving can in some instances be attributed to a faulty metabolism or glandular disfunction.

"Observers now believe that no one particular phase can be held accountable (for alcoholism); that the total personality is involved physiologically and psychologically. As in most illnesses, the two phases work together," states Dr. Block.

Socially the alcoholic "fits" or he "doesn't fit" depending upon whether or not his group sanctions excessive drinking and intoxication. If he "fits," he continues drinking openly with the group. If he is out of order, (drinks beyond the accepted norms) then he becomes belligerent and a problem to the group, or he will seek out a group where he fits, or he will try to drop out of society entirely and become a "lone drinker." If his family will not tolerate his actions he will continue on as a "sneaky drinker." But regardless of the group he belongs to, he is a problem to his family, his employer, and his community. For a long time this person is not aware of, nor does he admit, the fact that he has a drinking problem.

If the alcoholic has been raised in a good home he is going to be further tormented by an over-active conscience. Thoughts of "weakness" and "guilt", of unpleasant and embarrassing experiences are going to fill him with regret and remorse until he loses self-respect and confidence. Now the pain is so great that he must find relief. And where does the alcoholic go to find relief? Back to the bottle, in spite of previous promises and threats.

The alcoholic experiences *very real suffering.*

Until the attitudes of society change toward the sickness of alcoholism, everyone is going to suffer, either directly or indirectly. The answer is: more information through education with facts about alcohol and alcoholism. Only through mature understanding can we prevent and treat alcoholism. Although there is no known cure for alcoholism, treatment is necessary and can be effective in *arresting* the disease. The proof lies with the thousands of men and women living today who have overcome their problem, who have recovered, and have returned to their normal places in society; who have learned that as long as they don't take that first drink their case is arrested. They must be motivated with a stronger desire *not* to want to drink than a desire *to* drink. This can be accomplished in many ways as will be explained later.

The treatment of alcoholics could

go on indefinitely without gaining ground. Treatment is necessary, yes, but it is not the most important solution to this serious public health problem.

Only through the study and application of preventive methods have our public and private health agencies been able to solve such problems. How true the old saying: "An ounce of prevention is worth a pound of cure."

Methods for the prevention of alcoholism are still going through the early experimental stages in many parts of the world. At this point I would like to make a few personal observations and suggestions from my own experiences and study of the problem. These will be short and to the point.

Alcohol Education Important

We must in some way get information about alcohol and alcoholism across to boys and girls in the 14 to 21 age group. We must be uniform in what we teach. We must stick to facts about alcohol and alcoholism, avoiding all "Wet vs Dry" issues, leaving the moralistic aspects of the problem to the families and to the individual's conscience to interpret. With cooperative and coordinated support, this could be successfully carried out in the schools and churches, and in the doctor's office.

Young people must be informed of the facts . . . that alcohol is not a stimulant; it is a depressant, an anesthetic; that alcohol, circulating in the bloodstream through every cell of body and brain, has a direct effect on health and behavior; that alcohol slows down and impairs one's reasoning power, memory and reflexes; that alcohol releases inhibitions, causing us to do and say things we may later regret; that before anyone takes the first drink he should be well aware of the facts, the risk and responsibilities involved, as well as the effect it might have on friends and loved ones, not to mention the pocketbook; that drinking is not required by society, nor is it necessary for a happy and successful life.

They should know how to recognize, understand and have sympathy for the alcoholic. They should dread alcoholism as they would dread polio, cancer or diabetes. Here are a few facts published by The National Council on Alcoholism.

"The social, moral and financial losses occasioned by the deterioration of 5,000,000 adults are staggering. Contrary to general belief, the great majority of the alcoholic population of 5,000,000 are not visible "skid row" types of alcoholics found in the Monday morning court lineups, in the jails and in the city hospitals. Some 85% of all alcoholics are to be found in the homes, factories, offices and communities of America; they still have families, and are still employable; often they have exceptional skills."

As we read through this report we come across some facts that should make every stockholder and industrialist vitally interested in supporting any local program for the prevention and treatment of alcoholism. It goes on to say: "Wage losses through absenteeism in industry due to excessive drinking are computed at $432,000,000 per annum. In addition, the loss of valuable personnel who fall victims to alcoholism after years of investment in their training, is costing industry an astronomical amount every year."

We are wrong when we lecture or scold the alcoholic, calling him (or her) "no good", "lazy" and "weak-willed." There is an answer now for the alcoholic who says, "What can I do about it? Where can I get help?"

Alcoholics Anonymous was founded in 1935 and from humble begin-

nings has grown to a sober and successful membership of over 300,000 with over 9,000 separate groups functioning in all parts of the world. Its success is based on the fact that alcoholics work with alcoholics. Here there is understanding and example. Their program is based on spiritual principles and twelve important steps to a "new way of life." "Easy does it, first things first, and just stay sober one day at a time, asking God for help in the morning and thanking Him at night." In Maine there is an Alcoholics Anonymous group in every town, city and institution of any size. AA has the highest known rate of recovery of any type of therapy in use today for the treatment of alcoholics.

Since 1949, many states have been assuming their responsibilities in this matter of education and rehabilitation. Much help, information and guidance has been provided by the National Council on Alcoholism and the Rutgers Center of Alcohol Studies. Public acceptance has been much slower in coming.

Under the Maine State Department of Health and Welfare, the Division of Alcoholic Rehabilitation came into being through legislation in 1953. Since that time, through research, study and trial and error, much has been learned about rehabilitating alcoholics, and educating the public about alcoholism. The Division now has five full time Counseling Centers in Portland, Augusta, Waterville, Lewiston and Brewer. At any of these centers the alcoholic and/or members of his family can have their questions answered with sound advice, which if carried out (and herein lies the key) can start the alcoholic on the road to recovery. Counselors at these centers are trained and experienced in working with alcoholics and their families. Each interview is treated with strict confidence. Their methods of rehabilitation are based on diagnosis, counseling, treatment, and referrals to other specialized agencies or professions, where indicated.

The alcoholic must first want to find sobriety. Usually we can help him to reach this decision with patience and insight, not by scolding or preaching. When the alcoholic is ready to do something about his problem, he should not feel ashamed to ask for help. He can start by contacting his family physician, clergyman, Alcoholics Anonymous or one of the State Alcoholism Counseling Centers.

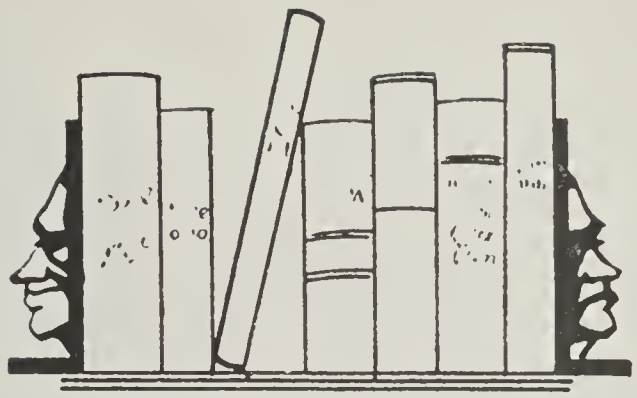
A Total Disease

But alcoholism being a total disease requires the total effort of the whole community to help the recovering alcoholic to find his proper place in society. In order to successfully do this, public attitudes must be changed. This is objectively being accomplished through factual newspaper and magazine articles, and through radio and television interviews, panels and dramas.

It is time people realize that unless something is done to bring this serious public health problem out into the open, every community will suffer through increased police, judicial, health and welfare costs, not to mention the broken homes, maladjusted children, highway and industrial accidents, etc. There is no end to the suffering and expense such a situation can create if allowed to continue by an apathetic public.

Alcoholism has been termed a disease by medical authorities and scientists working with the problem. No one afflicted with this illness should feel ashamed, nor should they be made to feel ashamed. But once recognized, there is shame in not doing something about it.

BOOK REVIEW



Recovery from Alcoholism. By Dr. Karl E. Voldeng. Henry Regnery Co. Publishers. Chicago, Ill. $4.00.

By all news media, magazine and book publication; by Public Health Service expressed awareness and by medical concern; by recognition of spiritual need by clergy and churches of many denominations; and by programs, by councils, workshops, civic clubs and social and welfare groups; the problems of alcoholism and of excessive drinking have been explored from all angles.

Now comes to the reading horizon a new book. Dr. Karl Voldeng, a general practitioner of sound scientific background and sensitive awareness of the needs of the alcoholic, has woven a realistic and practical narrative in the composite portrayal of an alcoholic; in his need, the steps taken in recovery, and his final achievement of sobriety.

Dr. Voldeng readily acknowledges how pitifully inadequate was his medical school and internship training to cope with the alcoholic patients he had in the early years of practice. He admits his conscience becomes uneasy when he recalls case after case poorly managed, progressive deterioriation and death of many a highly qualified, capable individual, and the sadness of failure even of specialists and institutional care to assist with recovery except in rare cases.

Nevertheless, since it is known and generally accepted by the unprejudiced and the well-informed that alcoholism truly is a disease, it seemed plausible and imperative to assume that medical men should take the lead in treatment and rehabilitation of the alcoholic.

The single case described in his book admittedly is a composite history of an alcoholic. As is so often the case, the doctor's help is sought without the alcoholic's knowledge or consent by some member of his family, his minister, neighbor, employer or friend. The difficulties of such an indirect approach are emphasized and discussed, and suggestions are given that might be more acceptable and have better success in making the initial contact between the alcoholic and the doctor possible.

This composite, representative alcoholic, Chris X, is described in all the bewildering, distressing complexity that characterizes most alcoholics. The pattern of his downhill progress is traced in the effects of his increasing, compulsive drinking, and in the behavior changes and deterioration that are so obvious to all about him, and yet which he so desperately tries to hide.

The evidences of physical sickness are shown; the troubles and ravages of emotional or psychological confusion are pictured in his unpredictable behavior; the sociologic significance of his progressive failure in his family, community and work relationships are revealed; and, most serious, his rejection by and departure from the spiritual fellowship of his faith mark the desperation of his total dissolution as self-respect and respect of others fades in ultimate personal agony.

The slow, uncertain steps to eventual recovery of sobriety are very carefully, very earnestly and very humbly suggested. But the steps suggested by Dr. Voldeng are nevertheless most reliable and rewarding. Medical care is posi-

(Continued on Page 19)

College Student Writes

I am a senior at East Carolina College in Greenville, N. C. preparing to do my student teaching. I am compiling a professional file to use during my teaching career. I would appreciate your sending me any material that you have.

Katherine Raynor
Greenville, N. C.

Request for Inventory

I am completing the Master's program in psychiatric and public health nursing at the University of Colorado and expect to be teaching soon. I would appreciate receiving your free publication, *Inventory,* to add to my file of professional literature.

Catherine L. Rogers
Denver, Colorado

P.T.A. Panel Discussion

I am interested in securing resource materials for use in the presentation of a panel discussion for a high school P. T. A. program, one area of which is to focus on Drinking and Teen-Agers. Any help you may have available will be appreciated.

Sarah E. Walker
Concord, N. C.

Informative And Helpful

Your *Inventory* is very informative and helpful. I was interested very much in the article "How a Municipal Court Helps Alcoholics" in the July-August issue. We have instigated such a program here at Family Court.

John V. Foster
Alcoholics Consultant
Family Court of the State of Delware
Wilmington, Delaware

Alcohol Education Week

We are planning an alcohol education week under the sponsorship of our Monogram Club. We have some excellent speakers lined up to discuss various aspects of the alcohol problem during the course of the week and I am in the process of ordering some films from the State Board of Health.

I would appreciate it very much if you would send me any free materials you have available such as pamphlets, posters etc. Each session will be scheduled during the school day and will be attended by approximately 200 students of high school and junior high school age.

Donald Y. Leggett
Director of Guidance
Buies Creek High School
Buies Creek, N. C.

Interesting Issue

I look forward to reading your excellent magazine every other month but was particularly struck by the July-August issue. We are trying to interest our Municipal judges to get some kind of program with alcoholics started here.

Jack Swift
Executive Director
Kansas City Council on Alcoholism
Kansas City, Missouri


Merry Christmas!
Raleigh ARP Staff
EDUCATIONAL TRAINING
SUMMER SCHOOLS
TRAINING WORKSHOP & INSTITUTE
INVENTORY

The ability of alcohol to addict merits lengthy discussion and comment as a cause of alcoholism when discussing the illness with all classes of heavy drinkers.

The Doctor's Responsibility to an Alcoholic

BY ARCHIBALD L. RUPRECHT, M.D.
UNIVERSITY OF WASHINGTON
SCHOOL OF MEDICINE
SEATTLE, WASHINGTON

SECOND OF A THREE-PART SERIES

Inventory is indebted to *Postgraduate Medicine,* a publication of the Interstate Postgraduate Medical Association, for the use of this article. The author, a clinical instructor in medicine at the University of Washington, is also medical director of the Seattle Alcoholism Treatment Clinic.

THE effort to take the stigma out of alcoholism by calling it a disease is commendable, but a few patients take this to mean the doctor alone will effect a recovery. People hope for wonder cures, since much sickness now responds to drugs that correct specific defects. Alcoholics incline to this thinking as they seek to absolve themselves of guilt. This form of denial is best scotched with thoughtful remarks about the disease concept. Some persons may be biochemically prone to alcoholism, but the proof is lacking. On the other hand, several studies attest the etiologic force of psychosocial factors. Patients and doctors alike need reminding that alcoholism, like most other biologic phenomena, doubtless has multiple causes. Inebriates on the "since it is a disease, cure me" tack may also be helped by the thought that if a simple bodily factor exists in some cases, there is heroism in surmounting but not in indulging a weakness. If a biochemical fault is one day found and proves treatable, that will be the time to emphasize it. If pulling one strand does not untie a knot, it is better to pull another than to risk making the knot tighter.

Ideally, talk about the causes of alcoholism should be brief and adapted to each patient. A display of interest in the disease is always a comfort, but there is risk of helping the drinker to intellectualize. Ability of beverage alcohol to addict is an exception and merits lengthy comment as a cause. Owing to drinking mores in our society, many patients are unaware of this property of ethyl alcohol. The hazard of addiction to narcotics is well known, but their social use is illegal and limited to tiny groups. Contrariwise, the drinking of alcoholic beverages is an acceptable and prevalent custom. Little wonder, then, the chagrin of an in-

Typical Progression of Symptoms of Alcoholism

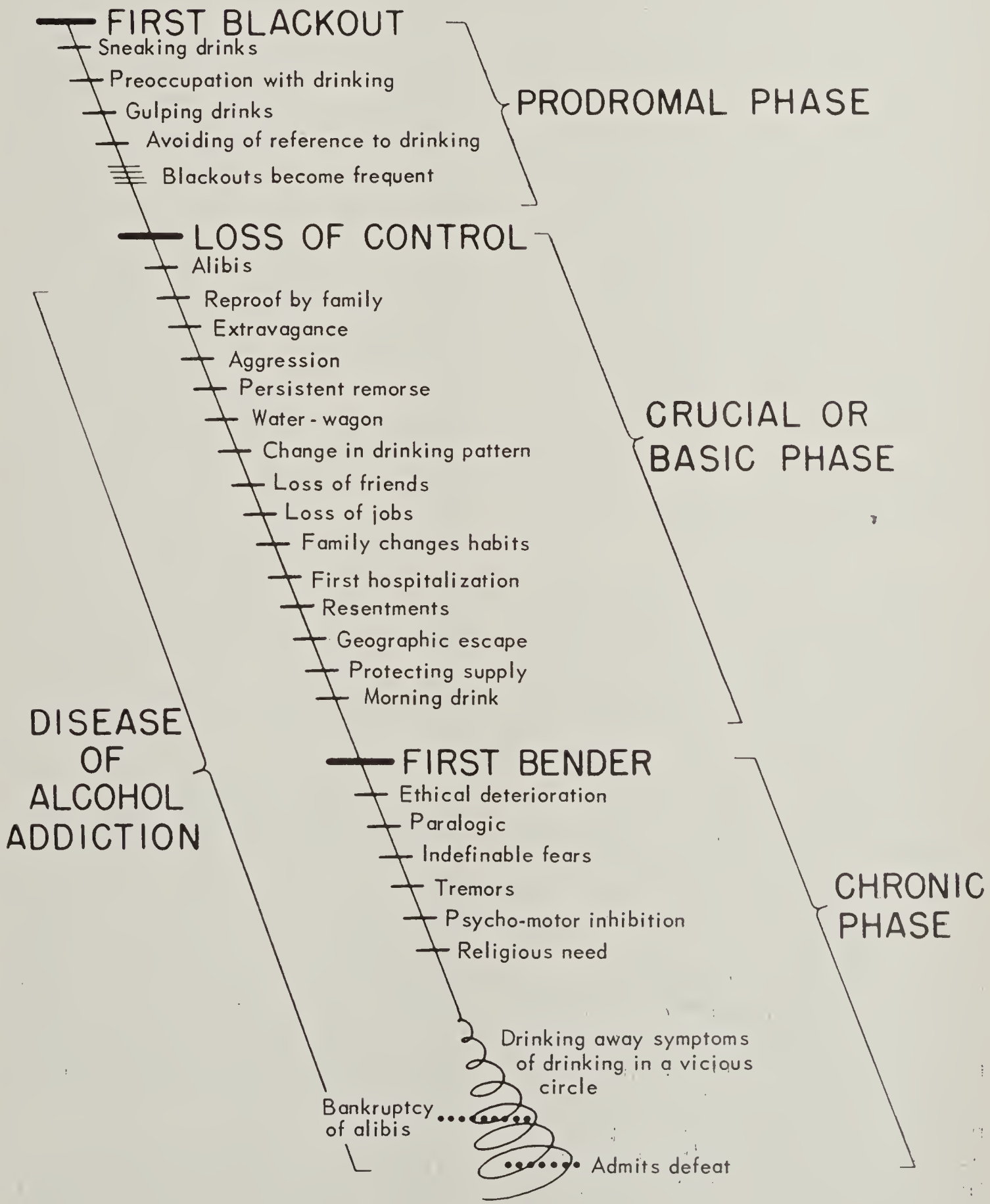


Figure 1

ebriate proud that he does not use "sleepers" to learn he is an addict just the same. Authorities debate whether ethyl alcohol is habituating or addicting, but this is a subtlety for pharmacologists, not patients.

With all classes of heavy drinkers, the danger of addiction to beverage alcohol may be stressed, the doctor explaining that inebriates use it to relieve emotional discomfort and that with an excess of disturbing feelings they can become victims of a pampering effect wherein they drink for ever smaller reasons until they imbibe to avoid the misery of withdrawal. Being outside the realm of the drinker's responsibility, this property of the drug is readily acceptable as one cause of alcoholism. Emphasis on this feature also helps the alcoholic realize, once his drinking is out of control, that recovery means abstaining. The public is aware of the risk if someone previously addicted to a drug uses it again.

Alcohol Addition

A good way to review with a drinker the signs and course of alcohol addiction is by reference to the Jellinek chart (figure 1) which depicts the typical progression of symptoms based on an analysis of drinking histories of more than 2,000 male addicts. Three phases are recognized: prodromal, crucial and chronic. The doctor should familiarize himself with key symptoms from each zone (table 1) to help patients locate themselves on the graph. Not every addict displays all items of behavior in each phase, but with guidance and interpretation he can easily take a bearing. The general course is plotted, and it remains for the patient to impose his own history. Inebriates typical of this severe form of alcoholism usually are grateful for perspective, and knowing that others have traveled the path lessens a sense of isolation. Nothing aggravates despair like uncertainty. Addiction to alcohol typifies only some alcoholics, but all should be educated on this point.

Limits on the use of sedatives should be set for each patient at an early date. Readiness to blame alcoholics for their abuse of these agents is at times a projection on the part of the medical profession. Does the doctor order a barbiturate or meprobamate without inquiry into drinking habits? Is he alert to a relative's request for sedation to shield the drinking member of the family from view? Does he ask what kind of pills lie stockpiled at home? Apart from questions like these, the physician must warn against excess use of some of these drugs, alternate them, and explain that they are for withdrawal and the tension of newfound sobriety but are not substitutes for alcohol. A time limit for their use after a spree should be set, and generally 10 days is a maximum. If the patient balks, either his relation with the doctor is not what it should be or more interviews and other supportive aids are needed. Even if sobriety is of some duration, a sedative should be prescribed only as a supplement to counseling and preferably when patients face stresses of predictable length.

Every doctor has favorite drugs to treat acute withdrawal states, but certain hazards deserve attention. Paraldehyde should not be used. From this the body makes acetaldehyde, also a product of ethyl alcohol and responsible for some symptoms of intoxication. Use of paraldehyde is thus hardly withdrawal and carries a high risk of secondary addiction.

The use of ethyl alcohol for impending delirium or in decrements to wean the alcoholic is also deplor-

(Continued on page 22)

VOL. 12, NO. 4 INVENTORY NOVEMBER-DECEMBER, 1962

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

The Nature of the Helping Process

BY ALAN KEITH-LUCAS, Ph.D.
PROFESSOR OF SOCIAL WORK
UNIVERSITY OF NORTH CAROLINA

Helping is a two-way process and what goes wrong in the helping may lie with the person who offers help or in the way in which it is extended.

Reprinted by permission, this article appears in a book by the author entitled *The Church Children's Home in a Changing World* published by the University Press, Chapel Hill, N. C.

TO help another human being may sound like a very simple process. Actually, it is one of the hardest things that anyone can be called on to do.

We all know our failures in the field. We know the person who refuses to be helped—the client who won't get medical care, the fellow who won't take the job we offer him even though it would seem that to do so was the most obvious common sense. We know also the man who accepts our help but uses it in a way that troubles us or seems self-defeating—the public assistance recipient who uses his grant to become more dependent instead of less so, the man who seems to accept our advice but somehow manages to pervert it so that it does him more harm than good. And we know perhaps only too well the person who uses our help as long as we are there to watch over him or "jack him up" but backslides as soon as our back is turned.

Our natural reaction is to blame the people who do this to us, or to attribute their failure to get and to use help to some inadequacy in them. We label them as immature or sinful or unco-operative or stubborn or just plain "no 'count."

What do we do then, once we recognize this wrongness? We can do any number of things, and from the Early Church Fathers to the heyday of the Poor Law and even into the era of modern scientific methods of helping, we, and society as a whole, have done one or all of them.

We have sometimes refused to help those who refused to help themselves, or who have used our help unwisely. We have washed our hands of them. Or we have tried to force them to do something about themselves by punishing them in some way, through starvation, or shame, or the workhouse, by the whip or the stocks, or by what is known as less-eligibility — forcing them to live at a level below what health and decency demand. Or again, if we are very patient and full of a desire to help, we have tried one of three methods according to our knowledge and taste. Sometimes we have gone on trying to help in the same way, believing that in the end the water will wear away the stone. We have exhorted and urged and persuaded and bombarded with good advice. Sometimes

we have hoped that if only they could learn to like and admire us, some change might be forthcoming, and we have been extra nice and non-judgmental and friendly.

I am not saying that people have not been helped in perhaps all of these ways. But I do suggest that all of those answers fail to take into account one very important fact about the helping process which is perhaps the key to helping on a deeper level. And this is simply the fact that helping is a two-way process, involving two people, and that what goes wrong in the helping may lie to no small extent with the person who offers help or with the process through which help is being extended.

Opportunity to Change

To give help really means to *offer someone an opportunity to change.* All other help is simply a patching up until the next breakdown, necessary perhaps for the moment but of no lasting significance. This was recognized by such pioneers as the Christian Socialists and the Charity Organization leaders of the last century when they fought to replace casual charity with planned concern for those in need. But those sincere people made one very great mistake. They thought that what went wrong with the helping that they saw all around them lay in *what* was given and not in *how* it was given. They thought that money or material things did not offer a framework in which change could take place and that intangible things such as advice, persuasion and friendly interest did. This is a mistake still made by many modern helpers, who exalt "services" such as counseling and ignore the help that can come from something as prosaic as a public assistance grant or transportation somewhere or a job or a little time to rest.

What these people do not see is that all help is potentially good if the recipient can choose to make use of it and that no help is good if the recipient doesn't. So that helping comes to mean *something tangible or intangible, offered in such a way that the person to whom it is offered can choose to use it*—that is, *choose to change* through its use.

But we do have to be very careful about this word "choose," for we use it in a rather special sense. To choose to use help means much more than to select a course of action or even to make up one's mind to do something. It means the decision of the whole person to go along with something, to do something about something, to risk oneself and everything one has in order to get something better.

This kind of choosing does not mean that the person being helped is free to do anything he wants without suffering the natural or legal consequences. It has nothing to do with freedom of choice in the usual sense. One cannot make it because one ought to or sees good reason for doing so or because someone else wants one to. For this kind of choice is terribly hard. It is terribly personal. And it is terribly dangerous. Truly, as in a wider context, one must lose one's life to gain it and to ask someone to change is to ask one knows not what.

For making this kind of choice always means at least four things. It means admitting your own failure. It means putting oneself more or less in the power of another, letting him know you and take a part in your life. It means hard work, for the choice has to be made again and again in different contexts, although the fact of having once made it makes it more possible the second and the hundredth time. It means risking the unknown; giving up a

present certainty, even though this may be an uncomfortable one, for a good which cannot as yet be fully seen.

And here it might be said that the correspondences between the process of asking for human help and the religious experience of conversion are so remarkable that they cannot, I feel, be entirely accidental. The words repentance, submission, steadfastness under temptation, and faith, are plainly corollary to the four elements that have been described here—a fact that is perhaps hard to realize until one has experienced both.

I do not suggest that this is exactly the same process. In fact, there is one very important difference. The person approaching God for help must try to submit entirely to His will. What individuality he maintains is then God's gift. He must also intend his submission to God's will to be permanent. The person seeking human help cannot submit to the will of the helper. If he does so he defeats his ends. In fact, he must always maintain his integrity as a separate person, against the will of the helper. This is, I would suggest, because the helper's will is of the same imperfect nature as his own and because human will tends always to control and not to set free. And again, the helped person makes this submission not forever, or even wholly for a time, but for a specific purpose and for a limited length of time. Nevertheless, he must admit the helper to some extent into his life.

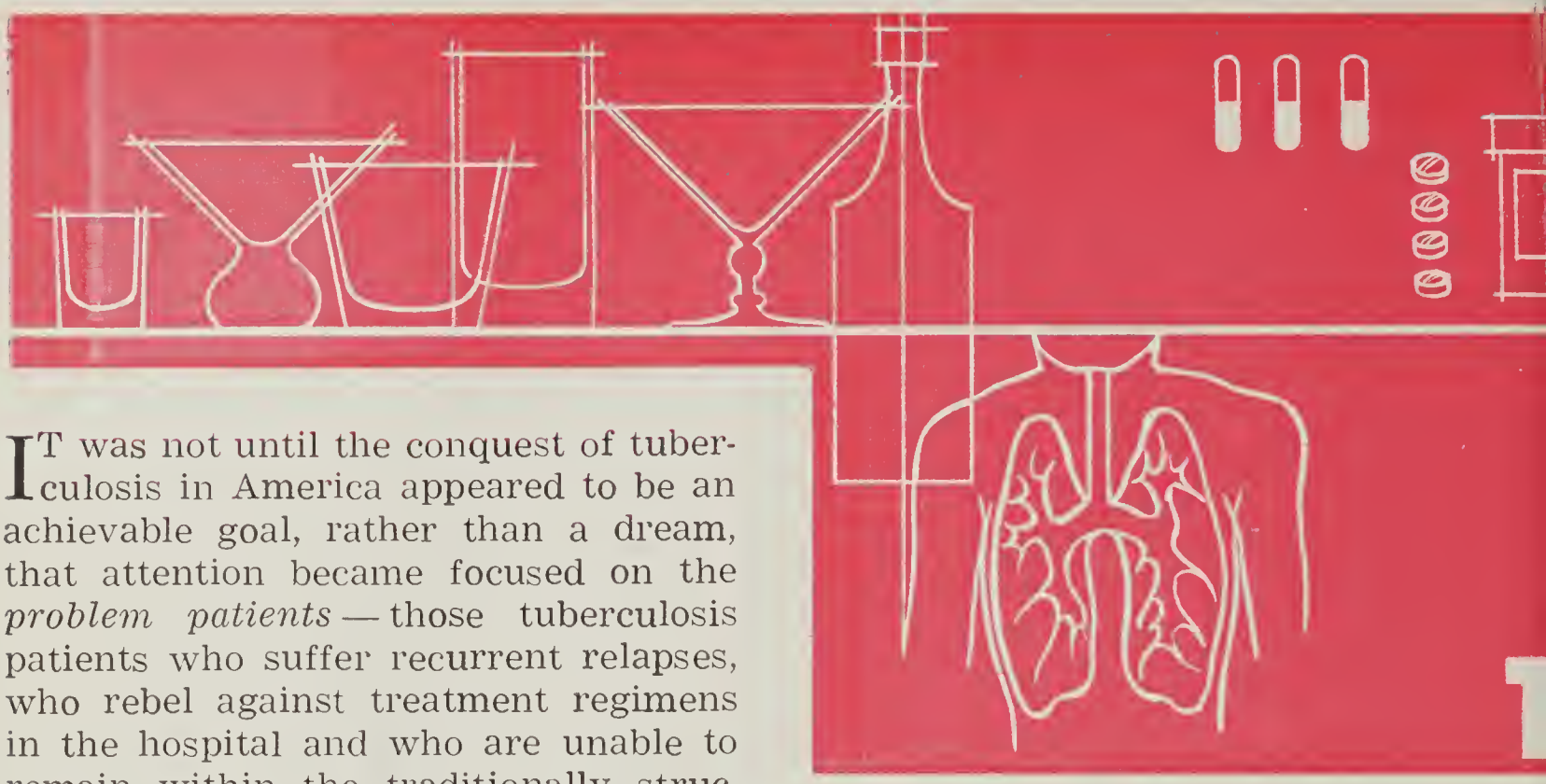
If this is what being helped means, is it then surprising that people will do almost anything to prevent themselves from experiencing it? Is it surprising that many of them refuse to admit their real need? Is it surprising that others demand help of us on their own terms—"give me my check and leave me alone"—as a means of warding off any demand really to change? One of the safest ways of not encountering God is to go to church every Sunday, sing all the hymns, and obey all the rules. Often enough the person who says that he wants help, who does what seems all he can to get it and yet finds it beyond his grasp, is in reality refusing it.

Let me try to illustrate this with a case. Here, for instance, is a longshoreman with a hernia that can be repaired so he can do light work.

A vocational rehabilitation counselor helps him get it repaired and finds him a job as a clerk. The client is co-operative. He keeps appointments. He tries to learn what he needs for his new job. He takes a position offered to him. But in a month or two he develops a psychosomatic asthma and has to go to bed again.

He wasn't a malingerer. The asthma was very real. He didn't sit down and figure out: If I get asthma I won't have to work. But in the recesses of his mind he was full of fears. He was afraid of his new job—could he succeed at it? He feared having once more to compete in a world of well men that would make no excuse for him, for he was no longer ill. And maybe he feared, too, what this new job meant to him. He was no longer the masculine figure tossing bales. He was pushing a pen—an old man's job that could be done by a girl. And so his mind and his body together threw up a protection for him. If he were sick, he was safe from his fears. And this, we are beginning to understand, is the real meaning of much of the sickness, both mental and physical, that we see in this world. More and more diseases are shown to be protections against pressures one cannot stand.

(Continued on page 30)



IT was not until the conquest of tuberculosis in America appeared to be an achievable goal, rather than a dream, that attention became focused on the *problem patients* — those tuberculosis patients who suffer recurrent relapses, who rebel against treatment regimens in the hospital and who are unable to remain within the traditionally structured sanatorium setting long enough to benefit from the new "miracle drugs." When the characteristics of these "treatment failures" and "recalcitrant" patients were examined, it was found that large proportions suffer from alcoholism, in addition to tuberculosis. This discovery suggested that the prevention of alcoholism might be an important aspect of tuberculosis prevention and that the successful treatment of tuberculosis in an alcoholic tuberculous patient is probably dependent upon the successful treatment of his alcoholism.

The profile of the tuberculous alcoholic patient which emerged is of an older, homeless male who has been highly mobile occupationally and residentially for many years. He has been jailed frequently for offenses directly related to excessive drinking. In the hospital he finds it difficult to accept the diagnosis of tuberculosis and impossible to accept the diagnosis of alcoholism. He often refuses to be hospitalized for his tuberculosis. If he is cajoled or forced into a sanatorium, his behavior brings staff disciplinary action; on occasion he refuses to accept treatment; he often leaves the hospital against medical advice, only to be readmitted at a later date.

Although this profile of the "recalcitrant" alcoholic tuberculous patient is substantially accurate, it is far from being descriptive of the "average" tuberculous alcoholic patient. In actuality, Skid Row alcoholics constitute only between three and seven per cent of all alcoholics. However, the research evidence shows that there is a higher rate of infection and of active TB in this group than in any other part of the American urban population. Without special detection and treatment programs aimed specifically at the Skid Row tuberculous alcoholic, his illness is not likely to be diagnosed without these programs; he is not likely to comply with the prolonged hospitalization and course of treatment necessary to cure or arrest tuberculosis. Higher than normal proportions of such patients will be found in sanatorium populations only in those states which have detection techniques reaching into city jails, missions, and county hospitals, and which strictly enforce quarantine laws. In many states, therefore, alcoholic patients hospitalized for tuberculosis tend to be from the same cross sections of the community as the non-alcoholic

ALCOHOLISM and TUBERCULOSIS

The solution to the tuberculous alcoholic problem demands the type of research, treatment, and voluntary efforts which have so successfully dealt with TB problems in the past.

BY JOAN JACKSON, Ph.D.

Published by permission of the author, this article originally appeared in the *Bulletin* of the National Tuberculosis Association. Dr. Jackson is a research associate professor at the University of Washington School of Medicine, Seattle, Wash. She is noted for research studies about the tuberculous alcoholic and family aspects of alcoholism.

ones. Moreover, they are infrequently diagnosed as alcoholics, since they do not come to the hospital from Skid Row or otherwise match the profile.

It is unfortunate that awareness of the problem of alcoholism as a complication in the treatment of tuberculosis arose from the study of "recalcitrant" patients. Partly as a result of this study, "alcoholic" and "recalcitrant" have come to be used as synonyms. Consequently, blinkers have been placed on our perceptions of possible solutions for the types of problems in which tuberculous alcoholic patients become involved. For example, when the Skid Row alcoholic or recalcitrant patient profile is used as a diagnostic criterion for alcoholism—which is only too often the case—it is impossible to recognize those alcoholics in the sanatorium who are "good" patients and "treatment successes." Thus, the knowledge to be gained from "good" patients, who are also alcoholic, regarding the factors which go into the comfortable hospital adjustment of some alcoholic tuberculous patients, and into their recovery from tuberculosis, despite alcoholism, is lost.

With this background, it is not difficult to see why most hospital staff members continue to react toward all tuberculous alcoholic patients on the basis of their experiences with those who are also "recalcitrant," not realizing that these represent only a small segment of the total tuberculous alcoholic population in the sanatorium. Negative staff attitudes toward tuberculous alcoholics are likely to help cause recalcitrant behavior, as well as result from it. Such attitudes may cause patients to leave the sanatorium or otherwise interrupt their treatment; the research evidence is strong on this point. These occurrences might be less frequent if staff members could be shown the total picture. It is obvious that the so-called problem of the alcoholic tuberculous patient continues to appear more hopeless than it really is.

The only way out of the impasse is to take a new look at the total situation and to change some of our diagnostic and treatment techniques. There is a sizable body of scientific literature on alcoholism on which such a new approach can be based.

The diagnosis of alcoholism must be divorced from any consideration of the patient's behavior in the hospital and

his previous social adjustment. A number of studies have shown that alcoholism, like any other disorder, can be diagnosed by drinking patterns and by a predictable symptom progression. To be sure, the tests for alcoholism do not have the concreteness of an X-ray or culture, but they are efficient in differentiating alcoholics from non-alcoholics, and in defining the stage of alcoholism as early, moderately or far advanced, or chronic. The symptomatology of alalcoholism was described as early as 1946, and progression of symptoms has been delineated since 1952. However, those who deal with tuberculosis patients tend to be unaware of these criteria for diagnosis and of the extensive literature on alcoholism. Diagnosis is still based on folk beliefs about the quantity and frequency of drinking, on behavior in the hospital, and on the Skid Row profile, rather than on scientific knowledge.

The treatment of alcoholism in the sanatorium, in the few places where treatment is given, also has tended to rely on folk knowledge. When the alcoholic tuberculous patient is admitted to the hospital, the major concern of the staff is with his tuberculosis. His drinking problems tend to be overlooked until an episode of drinking or recalcitrant behavior occurs. It is assumed that as long as he is not drinking, he is not suffering from alcoholism. It might just as well be assumed that if he is not coughing, he does not have TB.

If treatment of alcoholism waits on a recurrence of drinking, it is often too late. The Skid Row patient, in particular, is not likely to be around to be treated, having a drinking pattern which involves an extensive web of social relationships not to be found within the hospital walls. Even if the alcoholic patient remains in the hospital, the doctors and the nurses have a difficult time handling the aggravation of his drinking symptoms and an equally difficult time handling upsets of other patients, of hospital routines, and of their own feelings about the episode.

Although the hypothesis remains untested as yet, our knowledge of the relationships between tuberculosis and alcoholism has led to the belief that treatment of alcoholism must begin at the same time as treatment of tuberculosis and, to be successful, must parallel it throughout the hospital stay. While it would be ideal to have the ward physician treat both alcoholism and tuberculosis, at the present time this is impractical. However, in most communities there are agencies which treat alcoholism and which could help set up treatment programs for the alcoholic tuberculous patient. In addition, Alcoholics Anonymous members are willing to help alcoholics wherever they are to be found. Thus treatment within the sanatorium is not an unachievable dream.

If such community treatment facilities are to be used with any success, however, they must have the understanding and support of the sanatorium staff and the members of voluntary associations concerned with tuberculosis. The doctor and nurse must be in favor of the treatment programs and know how to present them to the patient in an acceptable manner. The voluntary association will be asked to interpret the program to the community and, perhaps, to provide volunteers and funds for aspects of the program. All of this means that everyone involved will be asked to invest a large block of time in already crowded schedules to learning about alcoholism and about its treatment. This cannot occur until there is more acceptance of the seriousness and permanence of the joint occurrence of

alcoholism and TB.

Alcoholic tuberculous patients will constitute an increasing proportion of patients within the sanatorium in the foreseeable future. This is not due solely to the rising rate of alcoholism in the general population and to the better detection techniques for alcoholism. To a much greater degree, the increasing numbers will be due to changes in the control and treatment of tuberculosis. More emphasis will be placed on detection among groups of the population who are known to have a high rate of infection and active disease. Moreover, until many of the problems in ensuring adequate treatment to alcoholic patients have been overcome, alcoholic tuberculous patients will accumulate in the hospitals merely because it takes longer to treat their tuberculosis.

It should be remembered that, in this century, the problems of treating tuberculosis were as difficult, and seemed as impossible of solution, as the successful treatment of alcoholism seems today. Tuberculosis victims were stigmatized, just as are our present-day alcoholics. They experienced the same kinds of attitudes from those who treated them and from other members of the communities in which they lived—but because workers in the field of tuberculosis were willing to face these difficulties squarely and act appropriately, the outlook for a world free of tuberculosis is brighter than at any other time in human history.

For those who are interested in the conquest of tuberculosis, alcoholism in tuberculosis patients is a highly important frontier. The solution of the problem demands the type of research, treatment and the voluntary efforts which, in the past, have been so effective in illuminating and successfully dealing with similar problems relating to TB.

BOOK REVIEW

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tive and explicit, yet enough flexibility is discussed that allows for differences in medical appraisal and need. Alcoholics Anonymous, with its proven record of success, is given credit for its effective fellowship program. Family counseling is an important element in treatment, for it is well known that ill-timed, well-meaning, but misdirected efforts of family members so often sabotage the most honest efforts of the alcoholic to remain sober. There is also a revealing chapter on the role that a minister can serve in the recovery program, for this perhaps is the most sensitive area of the alcoholic's search for sobriety: his conscious return to contact with God as he understands him.

Dr. Voldeng emphasizes the community responsibility in the restoration of a dangerously ill individual to healthy citizenship, transforming uselessness into usefulness. The teamwork of doctor, nurse, hospital, church, AA, family, neighbors, friends and employers is placed in admirable perspective.

Surely this book will find welcome in homes where alcoholism exists or threatens. Surely also, understanding of the environment in which the alcoholic best can be encouraged on his rough and narrow road to recovery is vitally necessary to all professions of service: for doctors, nurses, ministers, social service workers, and to all those to whom his life, his dignity and his personal integrity are important.

Those who have achieved sobriety know these matters well. Dr. Voldeng's book is a welcome floodlight on a dark area of our social, cultural and spiritual consciousness. —The Durham Morning Herald, Durham, N. C.

A feature designed to help you keep posted on developments in the field of alcoholism.

RALEIGH, N. C.: The NCARP and its governing body, the N. C. Hospitals Board of Control, sponsored exhibits at the State Fair held in Raleigh October 15-20. The theme of the Board of Control's exhibit was "Today's Research is Tomorrow's Treatment" while the NCARP had as its theme "How Much Do You Know About Alcoholism?"

NEW BERN, N. C.: The Alcoholics Anonymous groups in New Bern and Craven County held their annual banquet on October 27 at the Hotel Governor Tryon. Guest speaker for the occasion was Reverend Joseph L. Kellermann, director of the Charlotte Council on Alcoholism. Reverend Kellermann chose as his subject "God As We Understand Him." Approximately 265 persons attended the banquet.

WINSTON-SALEM, N. C.: The new Flynn Christian Fellowship House at 661 North Spring Street, which has been in operation since July 1, was dedicated recently. The dedication service was conducted by Reverend Brevard S. Williams, a member of the board of directors. The home provides living accommodations for alcoholic men as long as they remain sober. Those who are not employed do not pay for room and board but are encouraged to seek employment. After they find a job they contribute a reasonable amount weekly toward their room and board.

RALEIGH, N. C.: The NCARP will join in the observance of National Alcoholism Information Week which is being held November 25-December 1. News releases and radio and television spot announcements will be part of the special publicity that will be sent out all over the State.

BUTNER, N. C.: Dr. Donald E. Macdonald resigned his position as medical director of the Alcoholic Rehabilitation Center on October 1 to accept the directorship of the Mental Health Clinic of Charlotte and Mecklenburg County. Dr. Macdonald performed the duties of medical director for three years and, before that, worked with alcoholic patients at the Center while interning in psychiatry at the University of North Carolina. A Scotland-born psychiatrist, he is also a former director of the Wilson Mental Health Clinic. Dr. Mac, beloved by both the Butner and Raleigh staffs of the NCARP, will be missed, but has the best wishes of both staffs for success in his new position in Charlotte. Dr. Norman Desrosiers, a former chaplain at John Umstead State Hospital and at present a resident in psychiatry at the University of North Carolina School of Medicine, has been named acting director of the treatment center.

DURHAM, N. C.: A panel discussion on "Community Action on Alcoholism" was the feature topic of a meeting of the Durham Community Planning Council recently. Members of the panel, which included representatives of the Durham Council on Alcoholism; Mr. Haslin Simon, a Raleigh businessman; and Mr. Ray Newnam, counselor with the N. C. Employment Commission, told of efforts to establish an alcoholic rehabilitation center in Durham in the near future. Dr. Thomas Jones, a Durham general practitioner and rehabilitation chairman of the Durham Council on Alcoholism, has been instrumental in progress made toward setting up such a center. Other topics discussed by the panel included industry and alcoholism, employment and alcoholism and the work of the Durham Council on Alcoholism.

WINSTON-SALEM, N. C.: A series of monthly discussions on mental health topics, open to the public, will be sponsored this winter and next spring by the new Forsyth County Mental Health Association. Each discussion will be preceded by a film furnished by the National Mental Health Association. Following the film, the audience will participate in discussions with professional leaders in the field. The programs have been planned by Marshall Abee, director of the Forsyth County Program on Alcoholism; Dr. Joseph Cutri, instructor in psychiatry at Bowman Gray Medical School; and Mrs. Marian Duggins, nursing supervisor for the Forsyth County Health Department.

RALEIGH, N. C.: The semi-annual meeting of the Alcoholism Programs of North Carolina was held at the YMCA in Raleigh on November 2. A highlight of the day's activities was a luncheon address by Mr. Martin Peterson, assistant director of the North Carolina Prison Department.

DURHAM, N. C.: The Durham Council on Alcoholism recently sponsored a one-day program on "Alcoholism in Business and Industry." Featured speaker for the institute was Dr. R. C. Thompson, medical director of the General Electric plant in West Lynn, Massachusetts. Approximately 125 supervisors in business and industry attended the sessions held in the Jack Tar Hotel. Dr. Thompson outlined and explained how an alcoholism program in the General Electric plant has been instrumental in saving many hours of manpower.

BUTNER, N. C.: An art exhibit, sponsored by the Activities Department of the Alcoholic Rehabilitation Center, was held recently at the Center. The special exhibit, sponsored primarily for patients at the various State hospitals at Butner, featured the works of artist John Thomas Payne, who came to Butner in 1958 as a clinical psychologist at the Murdoch School.

WASHINGTON, D. C.: Researchers at Indiana University have found that experiments with white rats have revealed that rats with alcohol and caffeine in their blood made more errors than those that had imbibed only alcohol. And also, their judgment was affected for a much longer period of time than could be explained by the effects of alcohol. The doctors explained that if the same rats drank only alcohol, their judgment improved faster than if they took nothing to offset the effects of the alcohol. Thus, the researchers conclude, your chance of making it home safely may be better if you drive with only the alcohol in your blood instead of alcohol plus caffeine, if the results of tests on white rats hold true for humans. The drinker who has a cup or two of coffee after imbibing may drive just as poorly or worse than the drinker who drives with no coffee.

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ed. When a doctor prescribes alcohol, the patient finds it easier to feel that at times and for him alcohol is a form of medicine; there will be days when this logic will be tempting. If a doctor orders alcohol, he qualifies any prohibition against it. Value of this drug to calm the agitated inebriate cannot be denied, but combinations of chloral hydrate and the phenothiazines are just as good. An exception is a postoperative crisis when life is threatened by uncooperative behavior. Even here, earlier attention to the drinking history usually will bring to light the need for careful sedation to prevent such an incident. Chlordiazepoxide (LIBRIUM^{R}) recently has been described as highly effective in withdrawal states, but the proper dose seems to vary widely and proof of its superiority must await the test of time.

Alcoholics expose themselves to some chemicals often enough so that specific warnings are wisely given. Patients with a recurrent demand for sedation may take to self-medication with bromides, especially alcoholics lacking money or ashamed to seek a prescription item. A heavy drinker needs to know that bromide poisoning occurs and what the symptoms are. The relation of inebriety to severe or fatal reactions to carbon tetrachloride vapor also deserves mention. Alcohol circulating in the blood is thought to exert a solvent effect, prolonging the exposure of hepatic and renal tissue to the noxious agent. Caffeine intoxication is a common entity, especially in the fellowship of Alcoholics Anonymous; insomnia, tachycardia, extrasystolic arrhythmia, excitement and tinnitus may be on this basis. Whether or not to mention the dangers in the common nonbeverage alcohols is more of a question. Use of these by hardened drinkers does not seem to change with advice, but the sad cases are those of youths who imbibe these substances on a drunken impulse. Education in this area seems worth the effort for that age group.

A general physical examination has uses and abuses in this field. Doctors should be alert to the hidden alcoholic asking for a checkup. An appointment made by a wife or a new patient without specific complaints ought to be suspect. Regardless of how carefully individuals like these are studied, the visits are abortive and opportunities lost if alcoholism is present and not bared. Some patients look for reassurance, fearing their drinking is injuring their health. If a doctor misses the diagnosis and finds nothing wrong, the illness goes unchecked. Less excusable is failure to deal with the drinking problem a patient reports. A history and a physical examination are an inept response to this complaint if there is no effort to appraise or treat the alcoholism. All too often this is exactly what occurs. The patient wanting assistance with his drinking problem is given a big bill but no help; a patient-doctor barrier is raised. The physician is using an approach familiar to him for a problem on which he blocks or is poorly informed, but it is a sizable mistake.

If alcoholism is really the complaint the doctor should give it first place. Several office visits are well spent on details of the patient's difficulty with alcohol, how it evolved, and clues as to why. In the absence of acute symptoms, the usual history and physical examination are wisely delayed a month. A patient learns that the main concern is about his use of alcohol and that a checkup is secondary, a discovery that curtails hiding and denial. With this sequence, any assurance after an ex-

TABLE 1

Key Symptoms in the Three Phases of Alcohol Addiction

PRODROMAL	CRUCIAL	CHRONIC
Memory blackouts	Loss of control*	Benders
Sneaking drinks	Eye openers	Tremors
Gulping drinks	Alibi system	Protecting supply
	Changing the pattern	Unreasonable resentments
	Antisocial behavior	Nameless fears
	Loss of friends	Collapse of alibis
	Loss of jobs	Surrender
	Medical first aid	

*Represents transition from one phase to the next.

amination and suitable tests has greater meaning, the alcoholism being in the equation. These patients are more relieved than most to learn that their bodies are reasonably sound. Capitalizing on this, the doctor helps the alcoholic. Any drinker who associates someone with relief of one worry is motivated to deal with others. Proper timing of a physical examination allows maximum value from it as an act of reassurance and acceptance. By delaying it, the doctor is also more alert to tips he himself can use. The remark "I was the smallest baby ever born in Missouri" is irrelevant until the background of a patient's feelings of inadequacy is under study.

These remarks are misconstrued if taken to mean a physical examination can be postponed in a case of acute intoxication or withdrawal. Just the opposite is true. Errors and tragedies are legion from ascribing unconsciousness to alcoholic stupor without excluding other causes. Even if these patients are able to talk coherently, they are apt to lead one astray. Although many alcoholics report minor symptoms with the concern of an adolescent, others fail to mention what the average person would describe. The anesthetic effect of alcohol may, of course, make pain insensible. Less readily explained is the tendency to ignore symptoms such as cough and dyspnea. This may be related to masochism and a diffidence of the psychobiologic unit to complain. An alternative possibility is that symptoms are ignored for fear of what they mean. Whatever the reason, the doctor owes each of these patients a most careful examination. Having in mind the immaturity of many alcoholics, it is appropriate for the physician to be only half-satisfied with the history he obtains and to act like a pediatrician.

Any doctor caring for alcoholics should be able and willing to supervise a patient's use of disulfiram (ANTABUSE^{R}). Many physicians are afraid to prescribe this drug, although they employ hypotensive agents and anticoagulants at least as tricky. Unpleasant side effects and severe alcohol-Antabuse reactions are rare with the low dosage now used (0.5 gm. daily for two days, followed by 0.25 gm. daily). A patient who takes this drug regularly and takes a drink will quickly experience flushing, tachycardia, headache, nausea and vomiting. These effects are due to accumulation of acetaldehyde in the blood from a delayed metabolism of the ingested alcohol. Another important feature is that a patient who stops taking Antabuse cannot

drink without a reaction for four or five days, a period often long enough for a decision to stay sober and to restart the drug.

After an account of how Antabuse works and the symptoms drinking is apt to precipitate, a patient is best left to make his own decision regarding its use. This keeps blame off the doctor's shoulders for discomfort from a challenge and preserves the milieu of solving a problem together. Also, patients taking the drug of their own volition have less motive to prove it ineffective. Responsibility for a daily dose is with the patient, who should not delegate this to the spouse or other person lest a spat interfere with intent. Patients agree to sign releases absolving the doctor in the event of a severe reaction, and hesitant physicians are urged to require this. Other details about this agent which the patients should be told are found in an article by R. Fox published in the New York Journal of Medicine, May 1, 1958.

Patterns of Thinking

Alcoholics have patterns of thinking about Antabuse. Some fear it as a poison. This attitude usually changes when it is explained that Antabuse alone has no ill effect and the reaction precipitated by alcohol is from a high blood level of acetaldehyde, a substance present in smaller amounts after any drinking. Some patients decline for fear of leaning on a crutch. Telling them that they alone decide to use and administer the drug weakens this bias. Nobody is supporting them; they are trying to help themselves by taking a pill just as they help themselves when they consult a doctor or join Alcoholics Anonymous. An alcoholic who protests too much about a crutch may be rejecting aid, and the doctor may make this interpretation; often this feeling has broad implications. Some cardiac patients have a fear of the drug, but heart disease is never a contraindication to the use of disulfiram unless there is severe angina, postural hypotension or a propensity to faint. The hazard of a person's behavior while drunk should not be forgotten, and at times both patient and doctor need reminding on this point. Urging a patient to take Antabuse against his will is unwise, but a physician should be sure a drinker has the facts so that he may decide for himself. If the decision is not to use Antabuse and slips occur, the doctor may sensibly ask if the patient would like to change his mind.

Physicians wonder how a pill left to the alcoholic to take helps overcome a strong compulsion to drink. Important here is the conscious wish of many alcoholics to stay sober and the ideal use of the drug, which is with psychotherapy. Inebriates have trouble dealing with some of their feelings, this being one reason they use alcohol to excess. Many are unaware of the emotion troubling them. Antabuse returns a patient to the stage of coping with the feeling he may not have identified consciously or could not express. Concern over drinking becomes a concern over what feelings disturb him. Antabuse can also show the drinker how strong (or weak) is his desire to forsake alcohol and possibly how defiant he is. Whether the patient decides on long-term use or reserves it for periods of greatest stress, Antabuse is often a good adjunct. Wrongly thought of as an answer to alcoholism this drug really helps pose questions. For many patients it is a chemical fence enabling them to reorganize their lives with the help of Alcoholics Anonymous, the church, a doctor or a combination of these.

A RATIONALE FOR COUNSELING THE ALCOHOLIC AND HIS FAMILY

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This article, published by permission of the author, was originally delivered as a talk at the First Alaska Institute on Alcohol held at Sitka, Alaska, July 16-20, 1962.

A clinically-oriented research program focused, in part, on understanding the interrelatedness of alcoholism in the husband to marital and familial conflict has been in progress at the Division of Family Study, Department of Psychiatry, Medical School, University of Pennsylvania for the past eight years. The study has been supported with funds granted by the Division of Behavioral Problems and Drug Control, Department of Health, Commonwealth of Pennsylvania.

In this paper I report a rationale for treating the alcoholic and his family. This rationale has developed from our experience in the intensive study of alcoholics and their spouses and, more recently, from the study of the entire family unit in collaborative psychotherapy. By the latter I mean that both the alcoholic and the other significant family members are engaged concomitantly

in the treatment enterprise.

For the first several years this work was done by treating the alcoholic husband and his non-alcoholic spouse individually. In the past four years, however, the alcoholic husband and non-alcoholic spouse have been studied in group psychotherapy along with other such couples who are also maritally conflicted.

As our experience has progressed, it becomes increasingly difficult to view the alcoholic singly or as a suffering individual apart from those close to him and central to his everyday living. Since our strategy was, from the beginning, to understand significant characteristics of alcoholism and familial conflict, we made our therapeutic approach to both the alcoholic and his non-alcoholic spouse.

Interestingly, the morning before writing this paper, I was awakened by a dream that has relevance to the basic aspect of our therapeutic approach to the alcoholic and other significant family members.

As a small boy I was reared in the State of Indiana on the outskirts of its capital city, Indianapolis. When I was about ten years of age, a Chinese-American family who had a son my age moved into the neighborhood.

In the dream I recalled the immense pleasure this boy's father, Mr. Yen, gave me and my companions in teaching us how to construct a dual box-kite. With great clarity I recalled Mr. Yen telling us that it was important to purchase our pine wood carefully for construction of our kites. In some detail I could vividly see him laying out and nailing together the thin strips of pine into the two boxes. Then he repeated the most important consideration, "Always remember to save the strongest and most durable looking pine for the connecting links between

There is little evidence to

the two box-like structures." Mr. Yen re-emphasized the importance of the supporting structures.

It was the father's instructions to us that really stood out in the dream and has relevance to my thesis in this paper. I need to do little introspecting to understand why I had this dream this particular morning before preparing this paper. Our therapeutic approach at the Division of Family Study has focused upon the dynamic aspects of the interpersonal relations between the alcoholic and his spouse. More importance has been attached to understanding the nature of the relationship *between* such marital pairs than intrapersonal dynamics, i.e. what is going on inside the alcoholic and his spouse, or even in the personal meaning the alcoholic's drinking has for him. Attention is paid to the latter, however, to the extent to which excessive drinking arises and is related to interpersonal issues between the spouses.

In order to illustrate the implications of our therapeutic approach to the alcoholic and his spouse, let us examine a rather typical first contact with many alcoholics and their families.

Usually at a most inopportune time for the helping person—be he psychiatrist, social worker, AA member, or pastoral counselor—someone associated with the alcoholic reports a crisis situation related to the alcoholic's drinking.

For example: Mrs. X calls to state that her husband has been drinking throughout the weekend. She is anxious and fearful either to leave him, to take their small children to Sunday School, or to stay at home, since

support isolating and treating the "alcoholic alone."

he has become physically as well as verbally abusive to their twelve-year-old boy.

Mrs. X also relates that she knows her call early Sunday is poorly timed, but she has no one to turn to because all their friends and neighbors have become thoroughly disgusted with Mr. X's behavior. In fact, Mrs. X may add that she has expended great effort to conceal her husband's drinking from the neighbors but to no avail. "It's as if he just wanted to show me up in everything I try to do and stand for."

Both of the X's have completed high school with Mr. X taking one year of collegiate work before taking a position as an insurance salesman. They have been married approximately ten years marked with marital difficulties, have three children, and have moved from neighborhood to neighborhood in the same city in the past few years. Some moves have in fact been directly related to Mr. X's drinking behavior.

The above description represents a composite picture of many of the couples we have studied these past eight years when they are first contacted. My concern is what response does the helping person make to Mrs. X at this point?

On the one hand, the helping person may seek to ignore handling Mrs. X's plea himself by stating that he will send a local AA member over to contact her husband directly or by suggesting a direct referral to someone in the community, such as a doctor, who may have developed a reputation for helping alcoholics.

For example: The helping person inquires whether Mrs. X has heard about Dr. Jones whom, "I hear is good with alcoholics and has an excellent tie-in with the local AA group." Then he recommends that Mrs. X get her husband to go see Dr. Jones with little consideration being given to how Mrs. X is going to be able to motivate her husband to get to Dr. Jones, particularly in the light of the fact that she has found it increasingly difficult to meaningfully communicate with her husband on even less sensitive issues.

On the other hand, having equipped himself out of necessity (e.g., no other resources may be available) or professional and human interest to meet Mrs. X's plea for help, the helping person's initial response to her contact may well set the tone for the entire counseling relationship with the X's and its outcomes.

If, for example, the helping person believes that Mr. X's excessive drinking is mainly his problem alone, he may well invite Mr. X to contact him, give Mrs. X an appointment time, or inquire when he might be able to visit Mr. X. In addition, he may well decide that Mrs. X is in need of emotional support and invite her to see him independently for purposes of learning more about the crisis brought about, at least in part, by Mr. X's alcoholism.

All the above approaches are based upon the assumption that the alcoholic family member and his drinking behavior should be isolated and treated apart from others in the intrafamilial environment. The fact that studies have shown that 85 per cent of all known alcoholics have maintained ties with their families, I feel, gives us little theoretical or clinical evidence to support isolating

and treating "the alcoholic alone." Moreover, with couples such as the X's, one of the dominant problem areas which frequently emerges in treatment is that each spouse is prone to seek his individual goals and methods of adaptation.

If we listen closely to the alcoholic spouse, for example, we hear him complaining in one breath about the effect his wife's nagging has upon him and one moment later boldly stating that he must "solve his alcoholic problem alone", in spite of her harassment.

The non-alcoholic spouse, on the other hand, feels that their children's welfare and home are her sole responsibility because of her partner's inability or unwillingness to stay sober. In fact, the children as well as household possessions are referred to possessively as "mine" or "his" or "hers" rather than "ours" by both partners.

Dependently Troubled

We demonstrated in previously published personality studies of these couples, and similar results have been demonstrated by others, the degree to which both spouses are defensively prone to seek gratification of their individual needs in the marital situation with the children caught as pawns in a power-struggle more typical of adolescents than adults. Moreover, isolating the marital partners and treating them separately runs the risk of reinforcing these patterns of reaction. In fact, just allowing Mrs. X to ventilate about "their" situation without tactfully raising the question of how matters might have been between them prior to Mr. X's last drinking bout, serves to reinforce the existing quality of relationship because it has not really focused upon the relationship between the X's. The approach is not centered upon the supporting structures so needed by these often dependently troubled couples, as Mr. Yen would hastily remind us it should be.

The therapeutic rationale developed from our experience is focused upon the marital transactions existing between such marital pairs. We do not primarily treat the individual symptoms shown by the alcoholic or his partner. Instead, therapeutic energies are directed at supporting the dependent attitudes of both spouses with the alcoholic's symptoms being viewed as a barometer of his condition *vis-a-vis* his relationship with others.

The goal is to assist both spouses to understand better and to come to some decision about the difficulties existing between them in their family life. In order to accomplish this goal, we simultaneously approach both marriage partners and engage them in the therapeutic effort.

In our response to Mrs. X's call for help, we would, therefore, express our willingness to evaluate the situation *with both of them*—if we are to derive maximum benefit from our mutual efforts. In this type of couple not only our experience but that of others indicates that the spouse of an alcoholic is apt to be a troubled person.

This approach is grounded in our view of the family as a social action system whose principal components are made up of personalities engaged in a series of dynamic reciprocating interrelationships. Or, as other investigators have put it, "The family is like a jigsaw that must be put in one frame."

The fact that the alcoholic is the piece out of place means that other pieces are affected. In order to fit the mosaic together, we must appreciate the articulations of several pieces to one another. In clinical terms this requires that, following

the family crisis, the husband and wife—and often the children as well —must learn to adapt differently to one another so that they might function more effectively as a family unit. It is more than a matter of the alcoholic spouse reaching sobriety and behaving himself. It is a matter of mutual adaptation. It seems that this objective is better served by a therapeutic approach which simultaneously engages both the alcoholic and his spouse.

Fraser in a recent article suggests that the attitude of the wife and children toward the husband's sobriety are two of the crucial hurdles he may encounter in recovery from his illness. "Many an alcoholic who is doing a good job of maintaining sobriety feels that his wife is unnecessarily anxious about him and is always ready to worry for fear he is going to 'slip'. His irritation about this, if he isn't careful, can build up to the point where he begins to feel that he might as well 'give her something to worry about'."

In conjoint counseling we may aid the alcoholic in understanding his reaction and the contribution being made to it by his spouse's anxiety. At the same time we are in a position to identify with the wife and help her to recognize that her anxiety is not only the result of long and painful experience, but also that much of it is based upon genuine concern for him.

I am reminded here of a couple who were being treated in a group along with several other maritally conflicted partners. At one point the husband, who was an alcoholic, had remained sober for a nine month period. On the mast head of his boat, he attached a full bottle of whiskey to symbolize his sobriety and the fact that he was able to have alcohol present and not be tempted to indulge. To his wife, the bottle symbolized all the occasions in the past when her husband had yielded to temptation.

The group therapists along with the able assistance of the other couples were able to get each partner to appreciate the meaning attached to the physical symbol by each. Clarification of such perceptual discrepancies is more readily accomplished when both partners are made a part of the therapeutic enterprise.

In conclusion, we have found the joint approach to both the alcoholic and his spouse advantageous in altering the significant interpersonal relations between the alcoholic and his family to alleviate the critical situation which often faces such families. In so doing the alcoholic's attempt at sobriety is reinforced.

Particular emphasis has been given to spelling out the rationale for this approach which is in keeping with the wider therapeutic perspective of extending treatment to more than the "primary" patient in current therapeutic efforts.

There is no better argument for consideration of such an approach than the statement by Dr. Jerome D. Frank which closes his book entitled, *Persuasion and Healing; A Comparative Study of Psychotherapy*. Dr. Frank states, "No man is an island, and the degree and permanence of change in any individual will depend in part on corresponding changes in those close to him and on support from the wider milieu."

Howard E. Mitchell, Ph.D. is director of the research program about which he writes. He is connected with the Marriage Council of Philadelphia, Inc. which is affiliated with the University of Pennsylvania.

THE HELPING PROCESS

CONTINUED FROM PAGE 15

This is a state which, in my profession's peculiar jargon, we call ambivalence—wanting two contradictory things, feeling two ways at once. It is a paralyzing condition, so paralyzing, in fact, that it often looks like laziness, lack of moral stamina, being content with poor conditions, even feeble-mindedness. It is what "is wrong" with so many people that we think are inadequate. And helping very often becomes then *making it possible for people to resolve their ambivalance;* helping them choose (in our sense of the word) to get well, to change or not to change, to use help or not to use it.

For there are certain conditions which we know make the resolution of ambivalence more possible and free people to make the kind of choice of which they are capable. And the first, and perhaps the basic one on which all the others depend, is in itself a paradox. It is that a positive choice is only possible where the opposite choice is also possible and acceptable. Intellectually this may not be too hard to see. Man cannot choose to be good unless he can also choose to be bad. If God had compelled man to be good, he would not be good at all. Again, man cannot choose to live fully unless he can also choose (or accept) death. Nothing is gained without risk, and to say "Yes" sincerely always means that I could have said "No."

But this truth is terribly hard to recognize in practice. We so much want the man we are helping to make the right decision, to choose independence and not dependence, God and not the Devil. Even to recognize the possibility that he may choose the wrong seems like treason to us.

When we try to *make* someone into something that he has not chosen to be, it is utterly defeating. Man must always be free to do—even to "curse God and die." And we, and even our cherished values, are not, of course, God. What we think of as the wrong choice may for another person be right. Even if it cannot be, the choice must still be there. The risk must be taken. And the person who makes the wrong choice is much closer to help than he who makes no choice at all.

That is why I insisted that help must be help to choose to be well or to choose not to be well. All we can do as helping people is to set up those conditions that free a man to make this choice. And thus we come to the second condition, which is a corollary of the first. *The choice must be made by the person helped. It cannot be made, it cannot even be too passionately wished, by the helper.* For the helper to put his own will into it takes it away from the will of the helped; for the helper to push or persuade or cajole increases rather than resolves the helped person's ambivalence.

And this is why it is usually true, as a third proposition, that *people need a great deal more help with their negative feelings than with their positive.* They need to look at their negative feelings, to examine them, to discover their weaknesses. Their positive feelings usually get a lot of support. They are acceptable and everyone can weigh in with reassurance, hope or praise. It is their negative feelings with which they must struggle—their fears, their doubts, their hates, their despair. And this cannot be done, some psychologists and some preachers to the contrary, by pretending that the negative feelings are not there. They are. The man who exhorted us to "accentuate the positive and eliminate the negative" may have discovered a rule of social intercourse,

but he never had to help people in real trouble—which is why the extroverted, Pollyanna kind of helper who always wants to keep things pleasant is sometimes more harmful than helpful.

It follows therefore, fourthly, that the *helping relationship* must be one in which negative *feelings can be expressed without fear of blame, anger, sorrow, or loss of face.* This means in turn that it cannot be a relationship of superior and inferior, saint and sinner, wise and foolish, judge and judged, or even their modern equivalent, adjusted and unadjusted.

As helped and helper struggle together to understand, to come to a point where the helped person makes his decision, they must struggle as equals, either of whom could have felt and thought like the other.

It must deal with real things, however unpleasant. A doctor who refused to consider cancer of the anus because either he was afraid of cancer or he preferred to ignore the bathroom would be no doctor at all. So help with social problems must deal with what is really there—with real sorrow, real hate, real sin, and real despair. It cannot deal with false reassurance, with polite evasions, with "pie in the sky."

It must be based on trust, on the belief that man can be helped, however wayward he may seem.

And finally, and proceeding from this, *it must be based on humility* (in the Christian sense of the word). And this is because in the end you don't know what is right for another (you are lucky, indeed, if you know it for *yourself*); you don't have to face what he is facing (and pray God you never may have to); you don't, and you never will, know the length and the breadth and the depth of a man. Thus I end this list, as I began it, with a paradox. The more you know, the less you know.

These conditions for helping are what prompt me to ask of any would-be-helping person three very impertinent questions which are nevertheless very pertinent:

Do you really want to help? Do you want to put yourself truly at the service of another, which is not everybody's desire? Or do you in your heart of hearts want to be thanked or to control or to ease your own conscience or to serve some other end? If you do, I do not blame you. There is much else you can do, but helping is not your forte.

Are you tough enough to help? Any idea that helping is a "sissy" business is very far from the truth. It can be and is something that calls for every reserve of courage anyone can muster. It takes toughness to face reality, to risk anger, to strip the polite veils from sorrow to endure doubts and despair. It takes courage not to disarm them by glossing things over, by being self-righteous, by keeping things on a pleasant and utterly meaningless level.

Are you humble enough to help? Or in the last analysis must people be helped your way or by you and you alone?

I will share with you a formulation that I have found helpful as a check on what I am doing.

This is it. This is the real situation, stripped of all its polite coverings—what you really are up against.

I know that it hurts. As far as it is given to me I feel *for* you and *with* you in facing this trouble, and any time that you want to bring out your anger, your fear or your doubts it will be acceptable to me—not because I feel them myself but because I know that I *could* feel them.

I will stand by you to help you if you want me. I will not force you in any way but at the same time nothing will shake my willingness to help you should you ask it of me.

Currently in North Carolina there are fourteen

LOCAL PROGRAMS ON ALCOHOLISM

Educating the public is one of the major functions of these community groups and the key to prevention of alcoholism.

ASHEVILLE—

Citizens' Committee on Alcoholism
SGT. CARROL R. OWENS, CHAIRMAN
Municipal Building, Asheville

Educational Division, Board of Alcohol Control, West Wing, Parkway Office Building
DON DANCY, EDUCATIONAL DIRECTOR
Phone: ALpine 3-7567

CHARLOTTE—

Charlotte Council on Alcoholism
1125 East Morehead Street
REV. JOSEPH KELLERMAN, DIRECTOR
WILLIAM HALES, ASSOCIATE DIRECTOR
Phone: FRanklin 5-5521

DURHAM—

Durham Council on Alcoholism
602 Snow Building
MRS. OLGA DAVIS, EXECUTIVE DIRECTOR — Phone: 682-5227

GOLDSBORO—

Wayne Council on Alcoholism
P. O. Box 1320 — Phone: 734-0541
A. T. GRIFFIN, JR., EXECUTIVE DIRECTOR

GREENSBORO—

Greensboro Council on Alcoholism
216 W. Market St., Room 206 Irvin Arcade—Phone: 275-6471
WORTH WILLIAMS, EXECUTIVE DIRECTOR

HENDERSON—

Vance County Program on Alcoholism—Phone: GEneva 8-3274 or GEneva 8-4702
DR. J. N. NEEDHAM, DIRECTOR
2035 Raleigh Road

LAURINBURG

Scotland County Citizens Committee on Alcoholism
308 State Bank Building—
P. O. Box 1229
M. L. WALTERS, EXECUTIVE SECRETARY — Phone 276-2209

NEW BERN—

Craven County Council on Alcoholism, Inc.
409½ Broad Street—P. O. Box 1466
GRAY WHEELER, EXECUTIVE SECRETARY — Phone: 637-5719

NEWTON—

Educational Division, Catawba County ABC Board
REV. R. P. SIEVING, 130 Pinehurst Lane — Phone: INgersoll 4-3400

REIDSVILLE—

Rockingham County Committee on Alcoholism
225 West Morehead Street,
P. O. Box 355
MRS. ANNE WALL, EXECUTIVE SECRETARY—Phone: DIckens 9-4369

SALISBURY—

Educational Division Rowan County ABC Board, P. O. Box 114
PETER COOPER, DIRECTOR
Phone: 633-1641

SOUTHERN PINES—

Moore County Alcoholic Education Committee, P. O. Box 1098
REV. MARTIN CALDWELL, DIRECTOR
Phone: OXford 2-3171

WILMINGTON—

New Hanover County Council on Alcoholism, 316 Insurance Building
MRS. MARGARET DAVIS, EXECUTIVE SECRETARY—Phone: 736-7732

WINSTON-SALEM—

Alcoholism Program of Forsyth County
802 O'Hanlon Bldg., 105 W. 4th St.
MARSHALL C. ABEE, EXECUTIVE DIRECTOR — Phone: PArk 5-5359

OUT-PATIENT SERVICES

FOR

ALCOHOLICS AND THEIR FAMILIES

ARE PROVIDED BY THE FOLLOWING

MENTAL HEALTH FACILITIES

Competent Help Is Available At The Local Level

Mental Health Center of Western North Carolina, Inc.
415 City Hall
Asheville, N. C.
Phone: ALpine 4-2331

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
Chapel Hill, N. C.
Phone: 942-4131, Extension 336

Mental Health Center of Charlotte and Mecklenburg County, Inc.
1200 Blythe Blvd.
Charlotte 3, N. C.
Phone: FRanklin 5-8861

Cabarrus County Health Department
Concord, N. C.
Phone: STate 2-4121

Cumberland County Guidance Center
Cape Fear Valley Hospital
Fayetteville, N. C.
Phone: HUdson 4-8123

Gaston County Health Department
Gastonia, N. C.
Phone: UNiversity 4-4331

Guilford County Mental Health Center
300 East Northwood Street
Greensboro, N. C.
Phone: BRoadway 3-9426

Pitt County Mental Health Clinic
Pitt County Health Department
P. O. Box 584
Greenville, N. C.
Phone: PLaza 2-7151

Guilford County Mental Health Center
936 Montlieu Avenue
High Point, N. C.
Phone: 9929

Dorothea Dix Alcoholic Rehabilitation Service and Out-Patient Clinic
South Boylan Ave., Raleigh, N. C.
Mrs. Dorothy Ferrell, Psychiatric Social worker—Phone: TEmple 2-7581; Ext. 421

Mental Health Center of Raleigh and Wake County, Inc.
615 Wills Forest Road
Raleigh, N. C.
Phone: TEmple 4-6484

Rowan County Mental Health Clinic
Community Building
Main and Council Streets
Salisbury, N. C.
Phone: MElrose 3-3616

Cleveland County Mental Health Clinic
409 East Marion St.
Shelby, N. C.

Haywood County Mental Health Center
Haywood County Health Department
Waynesville, N. C.
Phone: GLendale 6-3542

Mental Health Center of Wilmington and New Hanover County
1013 Rankin Street
Wilmington, N. C.
Phone: ROger 2-8294

Wilson County Mental Health Clinic
Encas Rural Station
Wilson, N. C.
Phone: 237-2239

Forsyth County Program On Alcoholism
802 O'Hanlon Bldg.,
105 W. 4th St.
Winston-Salem, N. C.
Phone: PArk 5-5359

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bi-monthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department. Please request films as far in advance as possible and state second and third choices.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Displays—primarily for local public libraries; also available to school librarians and principals. All requests should be made through local public library to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
P. O. Box 9494
Raleigh, N. C.

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Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

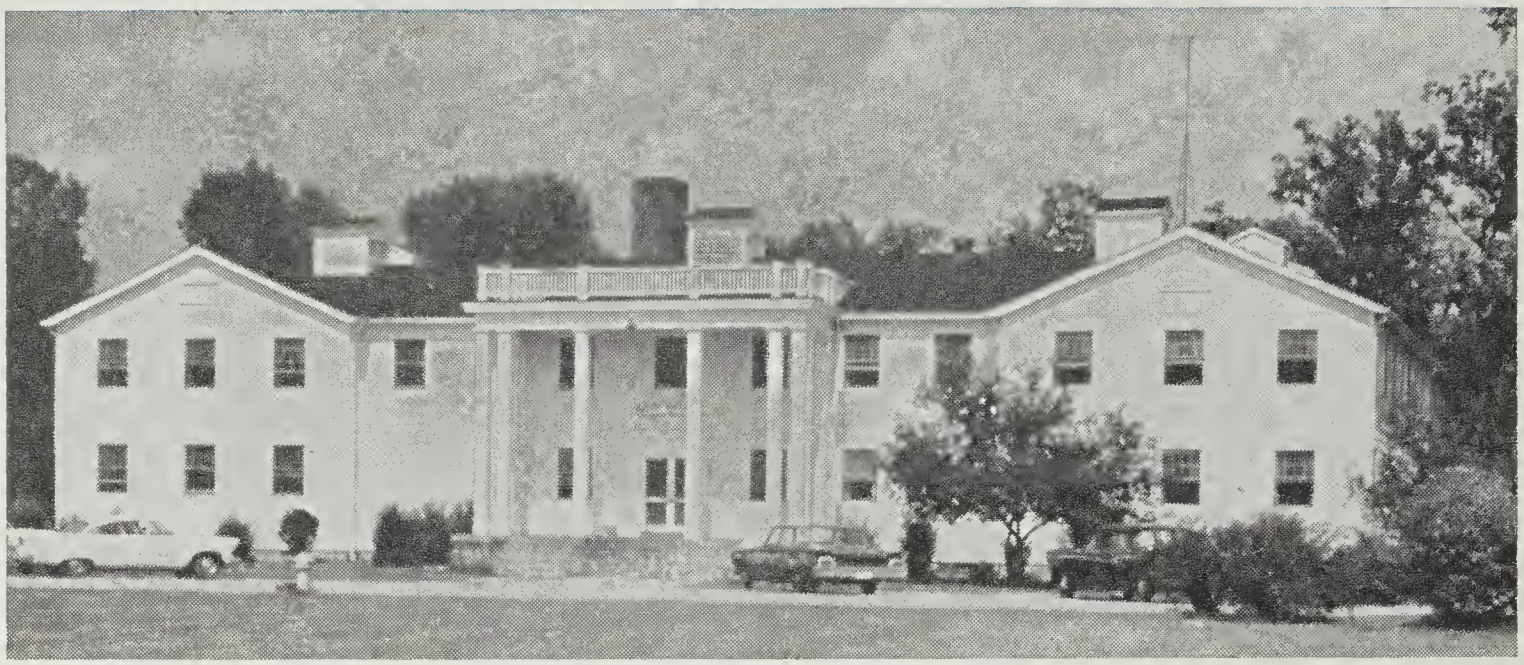
TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER



BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Medical Director, one other physician, a clinical psychologist, a psychiatric social worker, a chaplain and admitting officer, a vocational rehabilitation counselor, a recreation director-occupational therapist, and a full attendant staff.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment in response to written or telephone request to the Medical Director of the Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment. All appointments must be confirmed by mail.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Services Agency, and a complete medical history, compiled by the patient's family physician, are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M., to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
Patients must be sober upon admission, and in good physical condition. Patients may have visitors after they've been at the Center for 2 weeks. Visiting hours are from 1:00 - 4:00 P.M. on Saturday and Sunday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

INVENTORY

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SPECIAL FEATURE

DOROTHEA DIX HOSPITAL'S ALCOHOLISM AND DRUG ADDICTION SERVICE

Treatment by the Alcoholism and Drug Addiction Service of Dorothea Dix Hospital can be the beginning of a new life for the patient who will accept help.

This feature is presented in response to requests from local alcoholism programs and other sources. Acknowledgment is made, with appreciation, to the staff of the Alcoholism and Drug Addiction Service for their cooperation in providing information.

BY LILLIAN WILSON

MEN and women suffering from alcoholism or drug addiction come in great numbers to Dorothea Dix Hospital, Raleigh, N. C., sick and in need of help. Admissions per month exceed 120. The capacity for men is 109; for women, 40.

Although there is help for the alcoholic or drug addict who will accept it through the treatment service offered, the number of patients who purposefully and voluntarily seek out Dorothea Dix Hospital as a place for treatment is relatively small. Most of the people who come actually come involuntarily—either directly, as forced through the court; or indirectly, as dictated by social or family pressures.

As a whole, Dorothea Dix Hospital's alcoholic and drug addiction patients are not very well motivated toward accepting treatment. The elements of force and pressure to which the patient is reacting combined with the denial of anything being wrong, which is so characteristic in the illness of alcoholism, are not conducive to ideal treatment potential. The possibility of effective treatment is further hampered, sometimes, as a result of anger and resentment generated by methods used in getting the patient to the hospital. The latter usually occurs when the patient has been misinformed either about the hospital or the meaning of his admission.

Patients are frequently misinformed not only in regard to where they are being sent but also as to what to expect when they get there. Some patients have, in fact, arrived with their bathing suits expecting to find a country club atmosphere.

This misinforming is not necessarily the result of a lack of information on the part of the significant person who is in a position to persuade or force the patient into treatment. He may very well know exactly what the patient will find but, as a result of a distorted relationship with the patient, tell the patient a tale rather than the truth. "This is the best way to handle it," he thinks. "I won't tell Joe where he is going and he won't give me quite as much trouble."

The result is added difficulty for the hospital in its efforts to help patients. Many patients are so terribly disappointed when things aren't as they expected that it takes them the full thirty days to get over their dissatisfaction.

The patient should know before he comes that Dorothea Dix Hospital oper-

ates an active treatment center, not a country club. It is not a place for a "rest cure." Patients do not come for their "nerves." They come because they have a problem with alcohol or drugs.

The patient needs to know that the treatment service is designed to help the acutely ill patient and then, after the acute stage, to try to help him understand what his difficulties are and to help him do something about them through his participation in the treatment program.

No miraculous "cures" should be expected. Thirty days is no end of anything. It can only be a beginning of a different way of life if the patient is at all interested.

If the truth about the hospital were known to the patient in advance, the staff could spend much more time **treating** patients rather than **calming down** people who think it is such a "lousy" or "horrible" place.

In reality the patient is coming to the hospital for definitive treatment of alcoholism or drug addiction which takes place on closed wards, meaning behind locked doors. The hospital is responsible for the patient after he is admitted and there is not sufficient personnel at the present time to keep up with patients under an "open door" policy. Most of the governing rules and regulations are made by the State Legislature and cannot be changed by the hospital.

Another area which produces angry patients revolves around the exact meaning of their admissions.

Many patients believe that they are going to the hospital as a voluntary patient only to find after being admitted that they are under a court commitment. Others, while they are inebriated to the point that they may not realize the significance of what they are doing, are "over-persuaded" into signing themselves in "voluntarily" by frustrated relatives or friends who feel that there is no other solution to the acute situation of the patient. When they "come to" later, they find themselves in the hospital behind locked doors without knowing why or how they got there.

Legally, a person may gain admission to the hospital or be accepted for treatment in one of three ways:

1. He may come to the hospital bringing with him a letter from his physician recommending hospitalization and sign his own admission papers. This is known as voluntary admission.

2. A member of his family or a friend may obtain notarized statements recommending hospitalization from two physicians who are not related to the patient by blood and, if there is no objection to the hospitalization by the patient or any member of his family, the person will be accepted for treatment under the legal provision for hospitalization by medical certification.

3. The person may be committed to the hospital for treatment through the clerk of superior court in the county of his residence. This procedure is known as involuntary admission or commitment. In order to get the patient admitted involuntarily, two members of the patient's family and two physicians must sign affidavits stating that the patient is in need of hospitalization. The clerk then holds an informal hearing at which he examines the patient, proper witnesses and the affidavits. If he agrees that the patient needs hospitalization he may then issue an order of commitment.

Other Qualifications

The length of stay under all three procedures is thirty days. An appointment for admission must be made with the hospital before the patient comes. Either the patient or a member of his family must also pay a fee of $75 in cash or certified check when he is admitted.

Many patients are led to believe, or get the idea, that they are coming to the hospital as a voluntary patient when they sign a "waiver of hearing" back home. This is not true. Even though the patient himself institutes the proceedings, goes to the clerk of superior court, contacts the physicians, signs a waiver of hearing and comes to the hospital voluntarily, he does not legally qualify as a voluntary patient.

There is one and only one way for the patient to be admitted legally as a voluntary patient. In voluntary admis-

(Continued on page 15)

Help in Understanding

I have been given an old copy of *Inventory* and I want to extend my thanks for what these articles mean to me. I am a registered nurse and have just been on private duty with a patient who is ill with alcoholism. Your over-all coverage gives me so much help toward understanding alcohol problems. I am eager to learn more about handling this type of patient; however, we have very few in our hospital. I would like to have my name placed on your mailing list.

A Registered Nurse
Kinston, N. C.

Keep Inventory Coming

Please keep *Inventory* coming. I find it invaluable both in parochial work with alcoholics and with my efforts on our Hornell Council on Alcoholism. I would appreciate it if you would place on your mailing list my brother who is Catholic chaplain of Elmira Reformatory. He has succeeded in getting an A. A. group operating there after a long preparatory program of education (inmates and staff). I particularly want him to get your excellent July-August issue.

Reverend Vincent P. Collins
St. Ann's Church
Hornell, New York

Fine Magazine

I have appreciated your continuing to share your views on alcoholism with me through the past several years. I have found your publication to be one of the best thought stimulators as well as being chock full of up-to-the-minute information. My sincere thanks for past kindness and my very best wishes for your continued success in publishing your fine magazine, *Inventory.*

Leland J. Phillips
Alcoholism Program
Coordinator
South Dakota State Hospital
Yankton, South Dakota

Inmate Writes

Recently a copy of your very fine magazine, *Inventory,* fell into our hands. It was the March-April, 1962 issue. Many of us here found enlightening facts in the article by Dr. H. S., "Tell Your Doctor", and "Society's Ambivalence" certainly is worthy of the space allotted it. The praise of this publication could go on and on, but we are going to end with a thank you for the compact information in "What's Brewing?"

Through this group go back into society approximately sixty alcoholics every year. Some make the grade; some don't. The percentage, however, of those who are successful is commendable. We are at all times trying to make this percentage even greater and are well aware that magazines such as *Inventory* are invaluable assets to us in working toward this goal.

Most of all we want you to know that your publication is a worthwhile endeavor. It is what we need more of.

Anonymous Inmate
Attica Prison
Attica, New York

VOL. 12, NO. 5 INVENTORY JANUARY-FEBRUARY, 1963

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

The wife of a minister and University professor describes her nine-year battle with alcohol and her quest to "find herself", sobriety and Alcoholics Anonymous.

THE QUEST FOR A. A.

BY A WOMAN ALCOHOLIC

This speech was delivered by the author at the Southeastern School of Alcohol Studies at Millsaps College in Jackson, Mississippi in August, 1962. It was originally published in *Challenge,* a quarterly publication of the Alabama Commission on Alcoholism.

ALMOST five years ago I attended my first A. A. meeting. The nine years that had preceded that day—perhaps the most significant day of my life—were years during which I really had extended myself in every conceivable way looking for answers—looking for ways and means by which I might gain some measure of control over my life and myself. Never would I have believed that the day would come when I would be able to look back upon those years and accept the fact that for me, at least, they were the necessary preparation for the kind of life that I'm finding here in A. A.

The painful and disillusioning experience of those years was something that simply had to happen to me if I was ever to be broken of my willfulness, my pride and my blindness sufficiently to be able to see myself as I really was. I had to learn, and the process continues, because I still have to remind myself every single day, that I not only do not but that I cannot control anything or anyone, not even myself, by my efforts alone—I need help. Thanks to the ever-available help of A. A. and the ever present Grace of God, I still know this, even though this knowledge was born of considerable suffering. I now consider it the greatest insight, the greatest gift that I have ever had, because it places my reliance where it always should have been, in the hands of a power greater than myself, a power that I call God.

I went to my first meeting. I was not sure whether or not I was an alcoholic.

None of the terrible things had happened to me that I thought had to happen to a person in order to qualify as an alcoholic. I had never been unable to get sober. I had never been a morning drinker or a binge

drinker or an around-the-clock drinker. I not only had never been hospitalized for alcoholism, I had never even had to have a doctor to take care of me as the result of drinking and I certainly never had any brushes with the law. I still had my health, my home, my family, most of the friends that I cared anything about, and I still had the price of the next bottle. The people at that first meeting told me that one couldn't be a little bit alcoholic any more than one could be a little bit pregnant. It was all a question of the progression of the condition and they suggested that the fact that none of these terrible things had ever happened to me probably indicated I had been an extremely lucky alcoholic and also a very well protected alcoholic. They told me that all of these terrible things that had never happened to me not only could but most undoubtedly would happen to me in the inevitable progression of this disease if I continued to drink. They reminded me even though I had always been able to get sober by myself, I was not able to stay sober for any length of time. They suggested that perhaps I should forget about time in the sense of weeks and months and years and instead to concentrate on just one day and on trying to stay away from one drink for one day. They said, "You know that's what this program really is. It's based on a 24-hour plan during which we make a commitment to try with God's help to stay away from one drink for that one day and then we go to as many meetings as we possibly can because it is at these meetings that we learn how to use this program, and where we learn how to use and practice the twelve suggested steps to recovery. We learn how to participate in sharing our experience, strength and hope with one another."

Now this is simple, uncomplicated action, which is not to say that I found it easy action then or now. I think that if I had read this in a book, I wouldn't have believed it; I would have thought it was a vast, over-simplification of a highly complicated problem, which I suppose it is in some ways. But I did believe what I saw at these meetings, because I believed that those people knew what they were talking about; they had suffered what I was suffering; they had been where I was, and if this had worked for them, perhaps it could even work for me. And so A. A. became for me a kind of school, and after a lifetime of exposure in the academic community, ironically, it was here in A. A. amongst my own kind that I began the slow and laborious process, still going on, of learning the things that I had really always wanted to know, which were how to lead a meaningful and purposeful life.

For many, many years drinking was really a very occasional thing in my life. I was twenty-six years old, married, and the mother of two children before I really began to drink with what you could call regularity. And I had a few good years, as most of us do, before I started drinking. Almost from the beginning I was aware there was something different about my drinking.

And then one night—a night like any other night when I was drinking in my usual maner and my usual amount—I got terribly drunk and I had a blackout. I was thoroughly unprepared for this turn of events. At this time I had never heard of a blackout.

I was, however, already under the care of a psychoanalyst (for reasons obviously not connected with drinking) and so I discussed with him this strange phenomenon that had befallen me. He reassured me by say-

ing all the things that I wanted to hear: that this was the kind of thing that could happen to anyone once or even occasionally, but, fundamentally, he thought that it was symptomatic of the phase that I was going through in my treatment. He was not aware, of course, any more than I was, that I had already crossed that invisible line that separates those people who can drink successfully from those who can't. Neither of us was aware that drinking had already become the imperative factor in my life. I certainly was never drunk every day, nor was I drunk everytime I drank, but from that time on, regardless of whether I had a glass in my hand or not, the question of "to drink or not to drink" motivated practically everything that I did.

Nine-Year Battle

So began a nine-year battle for control—a nine-year battle to try to get back into the driver's seat—a nine-year battle to try to hide from myself the knowledge that I had indeed reached the point of no return as far as alcohol was concerned. I simply could not believe I had been licked by a thing like booze. And I most heartily believe, and in this I was supported by my doctor and by a great many people who knew me well, that if I could only find the key that would unlock the door and emancipate the real me, that I would be able to put some order in my life and in that order drinking would fall into its proper place.

I endowed this fantastic search for the will-o'-the-wisp, known as the "real me," with every bit of imagination and energy resource that I had. I searched for it in psychoanalysis, in an attempted career, in study, in worthy cases, in domesticity and home life; I even searched for it at Ebbetts Field in the days when the Dodgers were still in Brooklyn; and always and inevitably, I searched for it in the bottle. And here in the bottle, I really always found a key, but the door that this key unlocked was the door to a Pandora's box of irrational, unpredictable, destructive behavior.

The chaos and confusion that were created in my life, and in the lives of all those around me, by this attempt to lead two lives, one on a rational, constructive plane, and the other on an irrational, destructive plane, finally brought me to the point of despair where nothing seemed worth the candle anymore. The gap was just too wide—the gap between this person who made attempts at worthwhile living and this creature who was so beset by obsessive and compulsive drinking that she poisoned or kicked over every good thing that she did. This gap seemed to me insuperable, and I couldn't imagine that there ever would be a bridge wide enough to span it. And so I concluded that I was some kind of freak—a sort of typhoid Mary of the human race, and it was in this bleak and defeated frame of mind that I showed up at my first A. A. meeting.

Before very long, I found a key. It didn't open all the doors right away. It still hasn't. It never will. But it began what I hope will be a continuing process of opening little doors when I'm ready for them as time goes on. I found the key that unlocked the first door when I was able to accept the fact that I was an alcoholic—when I was able to accept the fact that there was absolutely nothing in the world I could ever do that would change that, but with the help of A. A. and the grace of God, I could change the meaning of it and take the destination of it by becoming a sober alcoholic one day at a time.

Every time I have ever spoken at

an open meeting in A. A. I have told one story. I have chosen this story to tell, not because it was the worst thing I ever did when I was drinking, or the most destructive, or the most humiliating of the things of a far reaching consequence. I tell this story because it seems to me to capsule, better than any other I can think of, what my life should have been—what, by right, might have been expected of me in this life and what I did with it as a result of drinking alcohol.

My husband is a clergyman. He is also the Chairman of the Department of Religion at a large metropolitan university. A couple of years before I came into A. A., he asked me if I would have a dinner party for the faculty and the staff members from his department at the University and I gladly consented to do this, of course, and I worked very hard to make this party a success. About three o'clock in the afternoon on the day of the party—the guests weren't expected until seven—I was all through with my chores and I was tired so I thought it would be a good idea if I took a little nap before the guests arrived. Then I had one of those brilliant inspirations that seem to occur to alcoholics. I thought "Maybe if I had a little glass of sherry it would help me to become drowsy." Now I knew a little glass of sherry did not help me to become drowsy. I knew it took a little bottle of sherry to help me to become drowsy. I also was one of the alcoholics who knew long before A. A. that it was the first drink that got me into all the trouble. I still didn't know anything about how one stays away from the first d r i n k. If I thought at all on this occasion, the only thing that occurred to me would have been something like, "Oh well, any fool would know enough to be discreet at a time like this." And so I took the first drink and you know the rest. I didn't have the luck to pass out. I didn't have the sense to leave home. I showed up at this party very nearly stumbling drunk, real hysterical—as I always was when I drank—muttering a stream of what was, fortunately, mostly incoherent jibberish. I say fortunately because what I had to say was not really complimentary to my husband and it was not expressed in the language one normally associates with a clergyman's wife. The people at the party were complete strangers to me. I had perhaps met one or two of them before. They were really not what anyone in the world would have called a drinking crowd. Most of these people didn't even smoke. These were the people, as a matter of fact, that I called "squares." You talk about arrogance. Here I was—boss' wife, clergyman's wife, hostess—drunk and disorderly and I had the nerve to refer to these people, who were behaving extremely well under very difficult circumstances, I had the nerve to refer to them in what I intended to be uncomplimentary terms.

I was so locked up in this little alcoholic trap; I was so involved with my own agony that I wasn't even able to tell this poor man, whom I had disgraced and humiliated, that I was sorry. I thought he ought to know I was sorry. I couldn't tell him. I thought he ought to know no one would behave this way if she were in control of herself. I don't know whether he knew or not. I do know that after that party he certainly knew that I no longer drank because I had large and unresolved personality problems. He knew I drank now because drinking had become my number one problem.

You might conclude that a performance like the one I have just described might constitute a "bottom"

but I didn't draw any such conclusion. I just wasn't ready to stop drinking then. I did decide that something had to be done about drinking and I was more successful with it than I had any right to be. I don't recommend it to anyone who hasn't already tried it because I learned some new things about loneliness.

I had thought I knew what it was to be lonely and the fact that I had a fine husband and two wonderful children didn't matter—I had these things and still felt as though I would die of loneliness. They had convinced me that I was a freak and reinforced my feeling of inadequacy. But after this party, the loneliness became a really morbid thing because I had decided I would try to be extremely careful of any drinking at all that I did when other people were around. Before long, I, who had been and am now a gregarious kind of person, no longer cared very much about being with people. I no longer wanted to make plans to do things with the children in the evenings or on the week-ends. I no longer even cared whether my husband sat and talked with me in the evening after they had gone to bed. I just wanted them all to "get the hell out and leave me alone to drink in peace!"

Except there wasn't any peace because there isn't any peace in solitary confinement and I was a prisoner. I was a lost soul in chains. Even though my chains may have been of the crepe paper variety, it is my opinion that these are the most difficult ones to break.

Now, thanks to A. A., I am no longer a prisoner. I have a choice. I can take one drink with all its consequences or I can do it the A. A. way and stay away from one drink for one day. I no longer feel like a lost soul because regardless of how often I may fail in the performance of my life, at long last it does have some shape. It does have some sense of direction. I do feel some meaning.

(Continued on page 31)

THIRD OF A THREE-PART SERIES

The Doctor's Responsibility to an Alcoholic

BY ARCHIBALD L. RUPRECHT, M.D.

UNIVERSITY OF WASHINGTON
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ANY physician interested in alcoholics will meet the markedly depressed inebriates and those whose drinking masks a psychosis. Suicide risks exist in both groups. The family doctor does not expect to treat the seriously disturbed, but he must recognize danger signals and any need for special care. It is part of his responsibility to inebriates. The earmarks of depression are many, but insomnia, anorexia and loss of libido lead the list. A psychiatrist's opinion is wise in a number of recurring situations with patients ill enough to fit these general categories.

The newly widowed or menopausal woman whose drinking worries her children may be mainly depressed and a good candidate for electroshock. If the doctor fails to recognize this, a useful form of therapy is withheld. A threat of suicide by an alcoholic should always be taken seriously, even if prior attempts were gestures. Alcoholism and its psychiatric substrate often constitute a progressive disease leading to mounting rage directed against the self. Both retarded patients and those whose depression includes agitation must be asked about suicidal thoughts, especially if they volunteer none. Some communicate the intent to take their lives to relatives or show it indirectly by drafting a will or buying a burial plot. Still another group whom reality frightens are those unable to stop drinking even briefly or who promptly trade alcohol for a different drug. Although the advent of new drugs for mental depression may encourage the general physician to treat some of these patients, severe cases require expert care; and if alcoholism is present, there is risk that the patient will use a psychotonic drug as a defense against other therapy for the drinking problem.

A different facet of the doctor's job is explaining the bodily effects of alcoholism. Many physicians feel this is wasted energy, but the narcissism typical of many alcoholics indeed em-

A feeling of personal interest on the part of physicians working with alcoholics and their families plus a ready knowledge of valuable treatment resources can't be over-emphasized.

Inventory is indebted to *Postgraduate Medicine,* a publication of the Interstate Postgraduate Medical Association, for the use of this article. The author, a clinical instructor in medicine at the University of Washington, is also medical director of the Seattle Alcoholism Treatment Clinic.

braces their bodies. With skillful choice of entities, the doctor can do much to implant an effort to avoid further damage. This suggestion goes hand in hand with another—not to lecture the patient; an unemotional, factual approach is best.

Each patient's history is the best guide in choosing lesions to discuss. If there have been bouts of known or suspected pancreatitis, its relation to steatorrhea and diabetes can be explained. Those who retch regularly need to learn about peptic esophagitis and the Mallory-Weiss syndrome. Anyone in or beyond the crucial phase of alcoholism, especially if aware of memory defects or personality change, will often take to heart a few words about cerebral atrophy. The combined effect on brain cells of asphyxial damage, malnutrition and multiple head injuries is easily described. Attempting to scare patients will fail, but if the choice of topics and manner is right, a doctor will be surprised at the genuine interest inebriates display. In most illnesses, the doctor knows eventualities and keeps them to himself; there is no point in worrying a patient needlessly. In alcoholism, the patient's behavior is a big factor in what develops and he needs a chance to plan an active part in prevention.

Patients in the early and middle phases of alcoholism often protest that business or social obligations require that they drink. Faced with this defense, doctors must take a firm stand. If the patient is in the prodromal phase but there is a march of symptoms, or if he has lost control of drinking, the physician must come out strongly for abstinence. Patients ask what to tell their associates or relatives. To admit to alcoholism appalls and may provoke only laughter and disbelief. These patients need assurance that they can learn to abstain. To friendly probing, their best reply is that they feel they have come to depend on alcohol too much. This is honest, cannot be disputed, and leads to a minimum of comment. Except in Alcoholics Anonymous, the notion of allergy is usually taken as a joke. Helpful to some in this dilemma is to point out Bacon's paradox. Drinking in our society has mores, and custom determines when we drink, how much, with whom, and at what speed. The alcoholic eventually violates all these rules and in this sense does not drink. If he feels he drinks to belong, he can and should be shown that he fails even as he tries.

Of all resources available to doctors trying to assist inebriates, A. A. is easily the most helpful. Many physicians know this but are unaware of how best to acquaint a patient with this fellowship. Someone not quite convinced he is an alcoholic cannot be expected to find his way to an A. A. meeting; the combination of doubt and shame is enough to deter him. Even those patients who accept the

diagnosis hesitate to confess it to strangers. An important part of the doctor's job is to help them into the organization.

Although newcomers are welcome at open meetings, a sponsor is advisable when there is intent to join. If a patient has a friend whom he knows or thinks is active in A. A., here is a good first choice. Failing this, a doctor should know an assortment of A. A. members in order to choose someone suitable to take the alcoholic to his first meeting. Similarities in age, interests, education and family pattern are generally worth observing. If patient and sponsor meet through the agency of a doctor, the defenses of a doubting novice are apt to be weakened. Just as physicians cultivate friendships with various consultants to permit the selection of an appropriate doctor for different types of cases, so they should be well enough acquainted in A. A. to call on members selectively. Doctors are very welcome guests at open meetings, which are excellent places to mix and broaden one's contacts.

If the patient has never attended a meeting, a brief description of what occurs is reassuring. Most patients have heard about A. A., but at times from the overly evangelical. A newcomer should not have unreal expectations. He needs to be told that occasionally someone attending will be drunk; at a gathering of persons trying to solve their drinking problems, learners like himself can be expected. The religious overtone to meetings may be mentioned, but a patient should not think A. A. is something akin to a quick conversion. Best he go expecting a friendly assembly of fellow sufferers at all stages of recovery, a chance to join a society of great and tested value to many alcoholics around the world.

A good technique is to schedule an office visit a few days after the patient's first meeting, to be sure he attended, to learn his reactions, and to ask if he plans to go again. If he does not like his sponsor, the doctor can suggest another. In a city with many A. A. groups, trying another group is good advice when the complexion of the first one is not to the patient's taste. Obviously, a highly educated person will find little in common with the membership of some groups. Any group should be attended at least twice before it is forsaken for another. Initially, regular attendance at several groups occupies many evenings a week and may meet an acute need for support.

When the doctor reinforces the referral to A. A. in these ways, the patient is less prone to drop out prematurely. He may be helped to understand his feelings by periodic review of reactions to events at meetings. Recommending A. A. to a drinker should not be a closed referral but an open-end one, with the physician making a continued effort to help the patient use the program. Self-resocialization is part of what occurs in this society, and being an ally on the sidelines is good therapy. Some persons steadfastly reject A. A. and should not be pressured. Rare is the alcoholic, however, who cannot derive some good from even a brief exposure.

Often neglected by the busy practitioner is the other side of the moon, the spouse or parent, landlady or lover whom the doctor never sees. As in moon-gazing, it is an error to mistake that which is lit for the whole. A key person at home is usually part of the problem, often playing into and aggravating the neurotic behavior of the alcoholic. Joined by a force relentless as gravity, together they defeat each other's effort at a less disturbed life. Treating the alcoholic and not the key relative is like trying to stand an

egg on end. A dent in the contributing behavior must usually be made.

Joint psychotherapy of husband and wife requires special skill. The average doctor does best to concentrate on either one, being content to orient and possibly direct the partner to an agency or another therapist. Especially helpful are the Alanon family groups. This offshoot of A.A. is composed of nonalcoholic family members who meet to discuss their problems and to gain insight and an understanding of how to help the inebriate at home. Every community has its special resources, but the Alanon groups are available generally and should not be forgotten.

Personal Interest Important

Periodic letters to patients who flirt with treatment are remarkably useful. The value of personal interest in working with alcoholics cannot be stressed too much. A thoughtful letter from the doctor is unusual enough to be good therapy and well worth the time it takes to compose. A patient whom the physician has seen but who is doing poorly is glad to know the physician still cares about him. At times, an alcoholic comes to a doctor's office under pressure to control his drinking, but then the pressure subsides and interest wanes. A note to this patient may alter his view of the physician and create a desire to return. Alcoholics who have requested care for withdrawal but fail to achieve sobriety are also good candidates. A doctor cannot go out of his way to play father to a large group of immature adults, but he can show feeling for them and a readiness to help. Although some alcoholics act to stimulate rejection by the doctor, his continuing interest may help them break this first link in their bonds. The feeling of embarrassment to accept help is often what the patient urgently needs aid to resolve.

To keep his equanimity and effectiveness, any doctor who treats alcoholics must have sensible goals. Out of place is the impatient notion that patients have simply to abstain. Indeed, therapy does not always stop with control of drinking, the ultimate aim being a more integrated and productive life. Generally, a doctor's efforts with early alcoholism will be the most quickly rewarding. In more advanced cases, progress is slower and irregular, and, to complete the spectrum, some patients either do not improve or deteriorate. There is value in recalling that these are the same categories into which patients with any of the degenerative diseases fall.

Even if progress is disappointing, some attempt to control drinking may alleviate the desperation at home. A minimal effort by the drinker may lead to mobility of the spouse, who may prove the more treatable. If the alcoholic shows a sustained interest in therapy, the first job is to help him learn why he is using alcohol to excess. The situations that usually lead to drinking should be stressed initially, since many patients slip into heavy consumption unware of what feelings it relieves. Alcoholics often indicate when they are ready to look deeper into their problems. How far the general physician goes in this area depends both on his interest and on his skill in psychotherapy. Some alcoholics have little capacity to learn, and the doctor's role becomes mostly supportive, as with many chronic diseases. A few patients are likely candidates for deep psychotherapy, and referral for this may be what a doctor readies them to accept. Initially, however, most alcoholics balk at seeing a psychiatrist, interpreting this to mean that the doctor thinks they are as crazy as they fear.

As with other diseases, some doctors will find they lack the interest or personality to work with alcoholics. Frequently a physician's reaction is that no patients are more frustrating; he forgets those hopelessly ill with cancer, many who suffer from physically crippling diseases, and the mentally retarded. If the doctor will cultivate new attitudes and use the knowledge he has about alcoholism in proper ways, he is apt to be pleasantly surprised. One reason an alcoholic is frustrating as a patient is that his drinking problem is usually ignored. How many operations have been performed for peptic ulcer disease with little or no effort to help the patients cope with alcoholism? To describe persons like these as frustrating is tantamount to making the same remark about a patient with periodic pulmonary emboli in whom congestive failure goes untreated.

Referral by Physician

It is not expected that all physicians can or want to be effective in this field. When a doctor becomes aware of a patient's alcoholism and does as much as he feels he can to help, to no avail, he must decide whether the patient sincerely wants help or is at present untreatable. If the first, or if there is any question, he owes him a referral. Whether the referral is to a doctor especially interested in alcoholism or to an agency, the usual preliminary telephone call to that physician or agency is in order. When the inebriate is sure the stranger he is to see knows drinking is the problem, he is more apt to keep the appointment. Blind referrals such as simply telling the patient to see so-and-so are discourteous. The doctor doing this betrays scorn and disinterest, and the patient is likely to resent the advice and fail to act on it. Referrals for alcoholism should be handled like all other referrals, especially since this will be peculiarly helpful to these touchy patients.

A final suggestion is a small lending library in the doctor's office. Some patients accept what they read more readily than what they hear, or at least assimilate it better. If an alcoholic wants more background than the physician has time to provide, the "New Primer on Alcoholism" by Marty Mann is a fine single source book. For persons inquisitive about A. A., "Alcoholics Anonymous" and "A. A. Comes of Age" are informative reading. For the occasional patient to whom a moral view has special meaning, Father John C. Ford's "Man Takes a Drink" is appropriate. If the patient is a candidate for intensive psychotherapy, useful volumes are "Alcoholism: Its Scope, Cause and Treatment" by Dr. Ruth Fox and Peter Lyon, and "Practical and Theoretical Aspects of Psychoanalysis" by Dr. Lawrence S. Kubie. For those who object to attending A. A. meetings but wish to ponder the program, "Sobriety and Beyond", a breezy and readable outline by Father Doe, is recommended. Patients may be urged to buy their own volumes but often delay because of the expense or effort, and a borrowed book often serves to bring the patient back for animated discussion.

Both Alcoholics Anonymous and the National Council on Alcoholism publish many small pamphlets helpful to patients and those around them. Favorites of mine are "13 Steps to Alcoholism" and "Do's and Don'ts for the Wives of Alcoholics." Both are available from the NCA office at 2 East 103rd Street, New York City, 29. Publications of Alcoholics Anonymous are obtained through local offices, listed in telephone directories.

sion, the patient obtains a statement from his physician, makes an appointment for admission, brings the statement and $75 with him, and signs his own admission papers at the hospital.

While there is absolutely no difference in the treatment that the patient receives, regardless of the type of his admission, there is a difference in his release.

A voluntary patient is discharged after thirty days. If he needs to come back to the hospital again, at any time, he must repeat the procedure for voluntary admission, or go through one of the other procedures, in order to be re-admitted.

Patients who have been committed through the court, on the other hand, are released after thirty days and placed on trial visit for one year. This simply means that should the patient need to come back to the hospital within the year, he can be re-admitted on the same commitment papers.

It is the probationary nature of his trial visit release that seems to infuriate the patient when he finds it out, even though there is no follow-up investigation by the hospital or the court. The trial visit is meant as a convenience when it is necessary to re-admit a patient within a short period of time.

Much patient dissatisfaction could be avoided and the hospital would not have quite as much resentment to "work through" if proper use were made of admission procedures.

Voluntary admission is applicable when the patient will go voluntarily to the hospital. Medical certification is applicable when the patient will not go voluntarily but will go without protest upon the urging of his family or advice of his personal physician. Involuntary admission through the court is applicable when other approaches fail. It is the least desirable method from the standpoint of treatment and should not be used unless this is the only way to get the patient who needs hospitalization to the hospital.

STATE-supported Dorothea Dix Hospital, located at Raleigh, N. C., accepts mentally ill, alcoholic and drug addicted patients for treatment as prescribed by law. Alcoholics and drug addicts are housed on the same wards and are treated by the Alcoholic and Drug Addiction Service. The following description of what happens to the patient after he is admitted and the treatment offered was compiled mainly from information obtained in discussing the alcoholic patient. Generally, however, the description also applies to the drug addict. An exception would be Antabuse therapy which is applicable only to alcoholics.

Both male and female patients first go to

the administrative office where their admission papers are checked for correctness and legality.

The women are than admitted to the hospital through the female general admission service and go from there directly to the female alcoholic and drug addiction ward.

There is a special admission service for men because of the larger number of admissions. After their papers are checked, the men go directly to a twenty-bed admission ward where the immediate concern is medical care for their physical problems. The patient remains on the admission ward from three to five days or longer, depending upon his condition. After the patient is able to take care of himself, he is transferred to the "continued treatment area" where all patients are ambulatory.

The male and female alcoholic and drug

addiction services each have a full-time psychiatrist-director and a registered nurse. A social worker is shared between the two. The service has a second psychiatrist on duty and two psychiatric residents who are rotated every three months. Student nurses spend three weeks on the wards as a part of their training. In addition to the regular attendants on the staff, new attendants in training are required to spend two weeks on the alcoholic and drug addiction wards.

The kinds of therapy available to the patient through the treatment program include: medical care, personal counseling, group psychotherapy, Antabuse therapy, education about alcoholism and drug addiction, including sources of help outside the hospital; and follow-up "after-care treatment" through the out-patient clinic.

Generally, the treatment for male and female patients is the same, although conducted separately.

Physical Examination and Medication

The patients, if not acutely ill at the time of admission, are generally in poor physical health. They receive a thorough physical examination on the day they arrive with appropriate medication for the major illness and any complications started promptly. Withdrawal symptoms receive special attention and medication is given, if indicated, to prevent them. Depending upon the need and severity of illness, the patient is given vitamins intramuscularly for six days and afterwards takes them by mouth. The patient is encouraged to drink plenty of liquids to replace fluids in his body and if he is unable to drink, fluids are given intravenously. Tranquilizers are also prescribed. Otherwise, emphasis on physical build-up consists of eating three good meals a day with "snack" schedules in between.

Interview with Social Worker

On the next day after admission, the patient, if he is able, is interviewed by the social worker. The social worker talks with the patient about what he **thinks** his problems are, what his difficulties are, and how he **feels** about them. Since the patient is treated on a closed ward (behind locked doors), a special effort is made to find out how he feels about being in the hospital: **What does he think brought him here? How does he feel about being here? What does he**

The patient receives a physical examination on the day he is admitted to the hospital.

think about the situation he now finds himself in? How long has he been drinking? When does he feel his problem with alcohol (or drugs) began? Does he feel he has a problem? Salient points gleaned from the interview are compiled in a social history which is passed along to the doctors to aid them in their work with the patient. The social worker also discusses any personal problems the patient may bring up, such as problems pertaining to his social, marital or job situation. Her services in personal counseling on any subject which may be troubling him are available to the patient on request throughout his stay.

Orientation Group Meeting

During his first week at the hospital the patient attends, along with other new patients, an orientation group meeting conducted by the director of the service. This occasion is utilized to explain the patient's admission to him and to answer any questions he may have concerning the rules of the hospital. It is suggested to the patient at this time that he is here because he has a problem with alcohol or drugs. The terms **alcoholism and drug addiction** are explained and the idea is injected that the patient is in fact, an alcoholic or drug addict and that is really why he is here. **"If you want help,' he is told, "we are here to help you but you must face reality and say, 'Yes, I have a problem or else I wouldn't be here.'"** What the patient can do about his problem while he is in the hospital is the final topic covered and he is told that he can participate in any or all of the therapies offered but wil

The patient, if he is able, is interviewed by the social worker on the day after admission.

Appropriate medication for the major illness and any complication is started promptly. Withdrawal symptoms get special attention.

The patient attends an orientation group meeting during his first week at the hospital.

not be forced to participate in any.

Group Psychotherapy

Patients who volunteer for group psychotherapy meet in small groups of six to eight patients with a psychiatrist for a minimum of one hour once a week. One doctor may have more than one group, depending upon the number of patients, and the groups may meet more than once a week, if the patients really want it. The aim of group psychotherapy is to instill in the patient an understanding of his emotions and unconscious motivations in the hopes that he will profit from uncovering the reasons for his drinking (or use of drugs) and, also, from relearning different ways of coping with his emotional dificulties. It is recognized that, in four weeks, the patient can hardly be more than introduced to the idea. However, the patient is encouraged to continue therapy after he leaves at some local resource, by associating with Alcoholics Anonymous, or by coming back to the out-patient clinic at the hospital. It should also be mentioned that not all patients are good candidates for group psychotherapy. The patient's level of intelligence, education, motivation, social background and sophistication are factors which influence his likelihood of benefiting from group psychotherapy.

Antabuse Therapy

Antabuse is a drug which has no harmful effects unless the patient taking it drinks alcohol. Even small amounts of alcohol plus Antabuse will produce extreme physical discomfort. The patients who join Antabuse therapy meet with the doctor in a minimum of four one-hour group sessions in which the properties of the drug and its proper use in helping the patient with his problem are explained. The patient takes Antabuse for seven days and is then given the "alcohol test" so that he will know what will happen if he drinks alcohol while taking the drug. With the doctor and nurse present, the patient is given from one to two ounces of whiskey. The resulting physical discomfort generally reaches its peak in twenty to thirty minutes. Vitamin C may be given to counteract the reaction. The patient who wishes to continue Antabuse therapy as a deterrent to drinking is given a prescription when he leaves and referred to his private physician.

Psychotherapy and Antabuse group sessions are led by a psychiatrist.

Patients participate in "music therapy" and conduct their own spontaneous musical "jam sessions."

Student nurses help organize and participate in recreational activities.

He also receives a card which says he is taking Antabuse and not to give him alcohol if found unconscious. Some form of follow-up therapy, such as group therapy or association with Alcoholics Anonymous, is also recommended to the patient on Antabuse.

Getting Together Meetings

"Getting together meetings" with a therapeutic intention are set up on a regular schedule with the exception of those conducted informally by student nurses on the wards. The student nurses are not assigned any functional duties such as giving medication or carrying out doctors' orders and are consequently free to spend all of their time interacting with the patients. They interview patients individually, talk with them in informal groups and help organize and participate in recreational activities.

Education and Information

Educational movies on the subjects of emotional health, alcoholism and drug addiction are shown once a week. A discussion period conducted by the social worker follows. As discussion leader, the social worker listens to, and comments on, the patients' feelings about, and reactions to, the subject matter. This time is also utilized to further acquaint the patients with sources of help on the outside, such as alcoholism information centers, mental health clinics, social service agencies and Alcoholics Anonymous. A surprisingly large number of patients are surprised to learn that there is anyone on the outside who cares enough to want to help them.

Alcoholics Anonymous

Members of Alcoholics Anonymous are invited to come to the hospital once a week to speak to the patients about the organization and how it can help them.

Follow-up Treatment at the Hospital

Former patients of Dorothea Dix Hospital may return to its out-patient clinic on Thursday afternoons at no cost to the patient. Those who live within a reasonable distance are urged to return for continued treatment. Any alcoholic or drug addict, regardless of whether or not he has been a patient at the hospital, may come to the clinic for treatment if he lives in Durham, Harnett, Johnston or Wake Counties. Treatment offered includes group psychotherapy and Antabuse therapy.

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Social Pathology, Urban Renewal and the Homeless Man

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I do not agree that research on the homeless man is the last social-psychological frontier—there will always be many. But since it is popular today to talk about "Frontiers"—especially the "New Frontier," let us discuss an old Frontier as far as sociology is concerned.

Since the pioneer classic sociological study, *The Hobo: The Sociology of the Homeless Man* by Nels Anderson, in the early 1920's, students of social pathology and urban sociology have shown a concern with this research area. Anderson, whose research technique was basically participant-observation oriented, brought keen insights to understanding the phenomenon of homeless men, but little in the way of statistical data.

Sociological interest in homelessness continued into the 1930's, mainly as a consequence of the severe economic dislocations of the Depression Decade. Anderson is again represented with his monograph, *Men On the Move*. It can be safely stated that in the 1930's, homelessness, far from being a deviant phenomenon, was the norm for a significant portion of the lower socioeconomic group.

Sociological interest in homelessness decreased with the full employment of World War II and its aftermath in the decade of the 1940's. However, during the 1950's, two major interests, or more appropriately, social movements, stirred the dor-

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Systematic research in urban sociology can help abolish Skid Rows by uncovering the societal and individual factors which give rise to Skid Rows and further their existence.

mant interest in homelessness. These were:

1. The public health approach to alcoholism which began to view this disorder in disease instead of moral terms. (A significant relationship had already been established between homelessness and drinking pathology.)

2. Urban renewal or redevelopment programs in the large American cities suddenly discovered that Skid Row areas, the habitat of the homeless, were scheduled for complete demolition. Crucial policy decisions about the relocation of these people had to be made; thus innumerable surveys on Skid Row populations have been conducted in Philadelphia, Minneapolis, Chicago, St. Louis, Los Angeles and other cities.

Information From Studies

Much of the information on homelessness possessed in 1962 is, therefore, a consequence of studies concerned with social policy concerning Skid Row and rehabilitation of Skid Row problem drinkers.

Therefore, this paper will approach the subject of homelessness in terms of two basic assumptions:

1. Skid Row, the center of homelessness and a specific locale in every major American city, serves concrete social-psychological functions, both manifest and latent, in the metropolitan community.

2. Homelessness in the male is symptomatic of more fundamental disturbances in either the economic structure of the society, i.e., the Depression; or in the social-psychological makeup of the individual, i.e., pathologies of alcoholism and psychiatric disease or both—the interaction of the socioeconomic position of the individual with his personal pathology.

The term, Skid Row, appears to have originated in Seattle at the turn of the 20th century. Yessler Street which sloped to Puget Sound was greased and logs were skidded down the street into the Sound. Along this Skid Road were many taverns, cheap amusement places, and hotels which were frequented by the males who came to Seattle during the log shipping season.

Seattle's Yessler Street formed the prototype of Skid Rows which are found throughout the Western World today—whether New York's famed Bowery, Chicago's West Madison Street, St. Louis' Chestnut and Market Streets, or similar areas in Copenhagen, Helsinki, Amsterdam, or Paris.

In American cities, Skid Row is located adjacent to the city's central business district in what the urban sociologist has called the zone of transition. It is an area characterized by severe physical deterioration; most of the commercial establishments and dwelling units are substandard. Institutional facilities are of the most marginal nature, composed of numerous cheap restaurants, hotels and "flophouses," religious missions and men's service centers, pawn shops and second-hand clothing stores, and drinking establishments.

Despite its unattractive appearance, the physical and social-psychological needs of a small section of America's urban population are met in these areas.

In the early days of urban redevelopment, certain American cities planned to eliminate these Skid Row areas through bulldozer demolitions. This naive assumption was constructed on the premise that Skid Rows were only a collection of obsolescent buildings. Much to the surprise of these planners, Skid Rows which were previously confined to one or, at the most, two areas of the cities metastasized to many locations

in the city. In short, Skid Row relocated, multiplying itself in the process. Later plans for redevelopment of Skid Row in such cities as Philadelphia and Chicago were preceded with social science surveys by Temple University and the National Opinion Research Center, respectively. These surveys provided scientific data on which to make policy decision concerning the relocation of the Skid Row population.

This experience in urban redevelopment points to the need for systematic research in urban sociology to study the historical factors associated with the development of Skid Rows, the social and economic forces in American society that further the continuance of these areas (even though on a smaller scale than in the period of the 1920's), and the patterns of recruitment to residence on Skid Row. Until we know more about the functions which Skid Row serves in the total pattern of urban life, most attempts to abolish Skid Row (such as current ones which attempt to remove individuals from this milieu through individual therapeutic techniques) will be doomed to failure. We, thus, must learn what combination of societal and individual factors give rise to Skid Rows and continue their existence.

As a consequence of theorizing and research studies on the problems of Skid Row and its inhabitants, conducted in the last decade by Dunham, Jackson and Connor, Bogue, the Temple University research group, and others, a vast amount of information is currently available to interested parties. We have only time to briefly summarize the major findings from these studies.

The Skid Row population has been declining in number for the last few decades and has undergone significant changes. Although it is still almost exclusively male in composition, it has been a less mobile population. A significant proportion of the men are permanent residents who are characterized by poverty and homelessness. Residence is found in the numerous missions, cheap hotels and flophouses which are indigenous to the area. Most of the men would be characterized as casual laborers. The incidence of drinking pathology as well as psychiatric and physical disease is high, although exact statistics are unavailable for the whole nation.

Statistical profiles of the charac-

teristics of Skid Row residents should be viewed with reservations, given the social isolation of the men from the large community and the close-knit social organization of some subgroupings on Skid Row. An illustration of one subgroup is that of the "Bottle-Gang," organized around obtaining wine, observed by Pittman, Gordon and Rooney. Earlier, Jackson and Connor had observed that Seattle's Skid Row was characterized by the existence of a prestige system; that there were group definitions for sharing alcohol; and that the men had developed systems for protecting each other from arrest for drunkenness.

Though Bogue and his associates in their study of Chicago's Skid Row found that the majority of men residing there could not be defined as alcoholics or excessive drinkers, the incidence of problem drinking cases is high in the Skid Row area. It is this area which contributes proportionately the largest share to the public drunkenness problem, both in arrests and incarcerations, in any urban center.

Chronic Drunkenness Offenders

Since the end of World War II there has been a vast proliferation of state and municipal programs dealing with alcoholism education, treatment, and research. The hard core of alcoholism cases are found in the 10 to 15 per cent of the alcoholic population which resides on Skid Row. These individuals comprise the largest portion of the over one million arrests made annually in the United States on the charge of public intoxication or drunkenness. A large number of these police actions involve the repeated arrest of the same men. These chronic drunkenness offenders are the men who are arrested, convicted, sentenced, jailed, and released, only to be rearrested—often within hours or days. They are the men from Skid Row for whom the door of the jail is truly a revolving door.

Much detailed information was gathered on the chronic drunkenness offender in a research study completed several years ago by Pittman and Gordon. Data was obtained on 187 cases of a random sample of men who were at that time incarcerated in the county jail and had been sentenced at least twice to a penal institution on a charge of public intoxication. The chronic drunkenness offender's usual habitat when not incarcerated is Skid Row—thus, the relevance to this discussion.

The extensive case histories of these men may be analyzed in terms of three major sets of factors which are crucial for the development of career patterns in public intoxication—sociocultural determinants, socialization determinants, and alcohol as the adaptive or adjustive mechanism in the life career.

The offense category of sociocultural determinants consists of individuals with definable sociocultural traits such as age, nationality, marital status, educational attainment and occupational skills.

Age is a major factor that differentiates these men from all other offender groups. Their age curve is skewed toward middle-age brackets. Their mean age of 47.7 years and their median age of 48.5 years are higher than those of the general male population, of arrested inebriates, and of patients seen in the alcoholism clinics.

The most frequently represented nationality groupings are English and Irish. Irish ethnics compose 35 per cent of the sample, but there is an increasing number of Irish with advancing age, especially after 45. Italians, although represented in significant numbers in the county's

general population, compose only 2 per cent of the sample.

The current marital status of these men is an important attribute. Forty-one per cent never married; 32 per cent are separated; 19 per cent are divorced; 6 per cent widowed; and 2 per cent were living with their spouses before the current incarceration. Thus, of these offenders, 96 per cent of those who had ever married reported broken marriages, whereas the expectancy is only 11 per cent, using the general male population of the county corrected for age disparities as the control.

On the whole these offenders are an educationally disadvantaged group. Seventy per cent of the sample did not go beyond the eighth grade of school compared to 40 per cent of the county's general population. This educational impoverishment is reflected in their low order of primary occupational skills. Sixty-eight per cent are unskilled workers, mainly laborers; 22 per cent skilled workers; and 3 per cent professional and allied workers—compared to 13, 46, and 22 per cent in the respective categories in the general population.

Summary

In summary, lower class individuals of Irish ethnic status and Negroes in the age bracket 40-49 with previous extensive arrest histories are most vulnerable to repeated arrests for drunkenness.

Within this framework of sociocultural determinants are a series of socialization experiences which are conducive to the development of a career pattern in inebriation. The structural continuity of the family units was broken by death, divorce, or separation before the inebriate's 15th birthday in 39 per cent of the cases. This is an extremely high percentage of families whose structure collapsed.

On a more qualitative level, mother-son and father-son relationships evidenced a trend in the direction of serious deprivations for the inebriates in meeting their basic emotional, social, and psychological needs. Thus, the sense of belongingness achieved by membership and acceptance in a social unit larger than the individual himself, such as the family primary group, was only partially achieved by most of the inebriates.

An objective index to evaluate adolescent socialization experience and the significance of these situations for positive identity formation was constructed by the following criteria: (a) participation in a clique or close friendship group of boys, (b) heterosexual participation as reflected in an established dating pattern, (c) existence of goals and aspirations, whether of a middle-class nature or not, (d) family integration as reflected in the individual's sense of belonging to the family unit, and (e) positive school adaptation as reflected in attendance and performance. If all of these factors were found in a case, the socialization experience was scored as good or above average; four present was scored adequate or average; and three or fewer was rated as poor or below what would be desired in socialization.

The results of these classifications indicated that the symptoms which warn of difficulties in assuming adult social roles are already present in these men at the end of the adolescent development era. By the index of adolescent adjustment, 86 per cent of our sample was rated poor; only 10 per cent could be rated adequate or average; while in 4 per cent the index could not be applied because of incomplete data. In only one case were all five factors present.

Thus the chronic drunkenness offenders are marked by difficult early socialization experiences in their original families and the adolescent sphere of development. This deficit is reflected in the adult inebriate career by the inability to perform two of the most demanding secondary task roles, i.e., occupational and marital roles.

The career of the chronic drunkenness offender is one in which drinking serves the socially handicapped individual as a means of adapting to life conditions which are otherwise harsh, insecure, unrewarding, and unproductive of the essentials of human dignity. This type of career is, however, only one of the possible patterns of adjustment, given the combination of conditions in the early life of these men.

Two Types of Patterns

Using the age at which a man was committed the second time for public intoxication or a drinking-involved offense as a breakpoint, the study group falls into two types which we shall designate the Early Skid and Late Skid careers.

The Early Skid career pattern involves approximately 50 per cent of the offenders. In this group two-fifths of the men experienced their second incarceration in their twenties and the rest in their early thirties. Only a few had their second imprisonment in the age period 36-39.

The Early Skid career pattern is thus one in which the individual establishes his record of public intoxication in his twenties or early thirties. It represents serious social and/or psychiatric maladjustment to early adulthood which extends into middle adulthood. There is an absence of adult occupational adjustment independent of institutional living. The period of alcohol dependency formation is not associated with such stable marital adjustment as may be found in some of the Late Skid career patterns.

The Late Skid career pattern is defined by the postponement of the minimum record of two incarcerations for public intoxication until the forties or even fifties. This career type encompasses 50 per cent of the men in the group, if the age 37 (for experiencing the second arrest) is used as the dividing point.

This period of alcohol dependency development is often marked by extended periods of occupational and family stability. Since this period is accompanied by drinking, it must be regarded as part of the conditioning period of alcohol dependency. More apparent in the Late Skid career is the physical decline of the man who is having great difficulty in maintaining his economic stability through marginal types of employment. Younger men replace him on the casual day-labor jobs. His drinking increases and finally his tolerance for alcohol declines.

In summary, the Early Skid career pattern is one in which drinking serves as the primary means of adjustment to original social and/or psychiatric disability; whereas the Late Skid career pattern is related to failure in secondary role performance.

The conclusions from the Pittman-Gordon study on the chronic drunkenness offender from Skid Row are to a large extent able to be generalized to the homeless population from the same area. This offender is the product of limited social environment and has rarely attained more than a minimum of integration in society. He currently is or has always been at the bottom of the socioeconomic ladder; he is isolated, uprooted, unattached, disorganized, demoralized and homeless; it is in

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DROG ABATEMENT

BY RALPH DANIEL
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Drog: a drinking fog that separates excessive drinking from alcoholism.

BEYOND the limits of normal social drinking, yet short of the stark reality of recognized alcoholism, there lies a foggy area where the drinking behavior is neither accepted nor rejected by our society. This drinking fog hides not only excessive drinkers but many people with good intentions who blindly grope to help with problems they do not understand. In this drinking fog of misunderstanding many little human problems, distorted by the mist, loom like terrible doom from which one must escape or die. In this "drog" (drinking fog) major human problems are distorted and dwarfed by the inability of society, and the individuals who belong to it, to see clearly what goes on.

The haze of the "drog" hides wives who weep secretly, foremen who fume secretly, doctors who dawdle secretly, social workers who squirm secretly, courts that complain secretly, and groups who gossip secretly. These groping guides cling pathetically to the hopeless hope that "sometime he may snap out of it." The density of the drog hides the simple truth that no one "snaps into" drinking problems nor does anyone "snap out of" drinking problems.

Drog, ironically, is an area that produces many jokes and a large amount of humor rises from the mists. Perhaps it is a nervous, insane humor where our culture laughs to keep from screaming.

The drog that provides a protected breeding place for alcoholism does not have to be. It serves no useful purpose. Knowledge is either available or potentially available to provide the foundation for a Drog Abatement Program that would clear the air and draw clear lines between excessive drinking and normal drinking.

First of all, we must understand the drog. How did it get here? What holds it here? What does it do to people? What does it do *for* people? What would eliminate it?

Drog is a sort of hangover created in a time of ignorance and maintained by social customs and popular misconceptions with which society has learned to live. Drog is a festering splinter beneath the skin of our culture and it will be painful to probe it out and clear up the infec-

tion. Drog is a smokescreen we have thrown up to hide our confusion about alcohol. Drog is an unrealistic tolerance of drinking excesses in others by people who are not comfortable about their own drinking.

Drog is caused in part by a wide variation in the climate of attitudes toward drinking. The transition from a nation that outlawed all beverage alcohol to a nation where most adults use alcohol has not been completed. It may take another generation. One segment of society labels all drinking as "bad" and advocates total voluntary abstinence if not legal prohibition. Most of our schools either ignore drinking as a social custom that future citizens must learn to understand, or they stress the negative results of drinking as if alcohol always does something *to* people and never anything *for* people. On the other hand, there are some who feel that alcohol is an essential part of good living and a necessary ingredient for social intercourse. Producers of alcoholic beverages advertise their products widely and alcoholic beverage is easily available even to those who the law says are too young to drink. These widely different "fronts" are bound to create a drog as they come together.

Alcoholism educators are frequently confronted with the drog rising out of the meeting of these widely differing "fronts". Many clergymen have considerable difficulty in facing the challenge of helping alcoholics because they see only the need to fight alcohol. Liquor interests, for the most part, remain aloof from alcoholism problems as though alcoholism were a disease invented by "drys" as a weapon against the "wets." Many groups avoid learning about alcoholism because they fear stirring up the "wet" and "dry" conflict.

Several years ago the writer was employed in a mental health education position where he gave talks on child growth and development. There was no direct charge to groups who scheduled these talks. Several child growth and development speaking requests came in after he left this position and was working for an alcoholism program. He offered to fill the request for a fee and travel expenses or to give the same talk but call it, "Prevention of Alcoholism Begins in the Home" (a title stolen from *Inventory*) at no direct cost to the group. Without exception, each of the groups paid to have reference to alcohol omitted. "Some of our members drink and some are opposed to drinking and we don't want to stir up an argument."

Changing attitudes and widely diverse attitudes will generally create a fog in which some people will get lost. It is hard to conform to a social order that can't make up its mind.

There is another, and perhaps more subtle, cause of drog. Probably the most welcome effect of drinking is found in the relaxing of tensions and inhibitions. A look at the tensions and inhibitions of our times may offer some clues to the fog that separates acceptable social drinking from alcoholism.

There has come about, largely through ignorance of good mental health, a belief that some feelings or emotions are "good" and some are "bad." Anger, fear, hostility and hate are considered to be negative, dangerous, and unwanted feelings. Love, optimism, hope, ambition, faith and cheerfulness are considered positive, constructive and desirable feelings. The people one lives with tend to evaluate him on the basis of the way he exhibits "good" emotions and hides "bad" emotions. There have been created among us countless acceptable methods of showing "good"

feelings and pitifully few acceptable methods of showing "bad" feelings. Not yet has society accepted the concept that feelings are neither "good" nor "bad" but rather *natural* emotions that come to all humans and that the labels "good" and "bad" can rightly be applied only to the methods used to express feelings. Not yet has society accepted love, ambition, and hope as possible creators of negative results—or fear, hostility and hate as possible creators of positive results.

Basis of Tensions

This set of values, handed down by generations when the knowledge of human personality was meager, forces man to hide, repress, and camouflage some powerful, normal feelings and to fake the expression of the so-called "good" emotions. This repression and this faking provide the basis of most of today's repressions and tensions.

The first effect of drinking is the gradual anesthetizing of the part of the brain wherein lie the tensions and repressions. The society that inspires these tensions and repressions allows people to loosen their grip on them in drinking situations. The use of alcohol provides a sort of license to relax from the inhibitions and taboos that are normally present.

Drinking customs that make acceptable those things that are otherwise unacceptable, make substantial contributions to the drog. Even normally unacceptable "excessive" drinking may become acceptable as the group starts drinking. We verbalize a concept that drinking and driving are incompatible, yet a very small per cent of drinkers will avoid driving when there is need for transportation. A drinker may be the "life of the party" one night and feel the need to apologize for his actions the next day.

Even if these two conditions were solely responsible for the drog where alcoholics hide, a drog abatement program would not be simple. The widely different attitudes about drinking cannot suddenly give way to better mental health.

The modern alcoholism education pioneers have avoided the drog areas. They have attempted to draw a sharp line between themselves and the vanishing "drys" who considered drinking per se to be bad. Lest these health educators be confused with reformers who would eliminate all drinking, they have insisted that they deal only with the problems that concern the alcoholic.

Originally, this distinction may have been necessary, but if steps are to be taken toward prevention, the drog must be penetrated and studied and cleared. The specific causes of alcoholism may be unknown at this time. It is clear, though, that the reluctance of people to treat the early symptoms of an illness as anything more than humorous or as a phase some people must pass through is more than a barrier to early treatment. It is a barrier to progress in understanding causes. The observable actions of early stage alcoholics are not clearly different from the actions of many non-alcoholics who get lost in the gray zone that lies between normal social drinking and the stark, tragic glare of recognized alcoholism. Progress toward alcoholism control may well depend on a drog abatement program.

Fifty years ago, it would have been folly to talk about clearing a fog that is deeply rooted in social custom. Fifty years ago a social custom was accepted as "one of those things" that "just happens" and cannot be controlled or altered. Modern sociology has made rapid strides and

the person who can wade through the sociologist's jargon will emerge with the exciting hope that new broadly acceptable goals and methods can clear up those smokescreens of social customs that provide breeding places for enemies of society.

The time has come when the knowledge of alcoholism and the knowledge of the making and the changing of social customs could be combined for the elimination of the drog that presents the greatest barrier to the control of alcoholism.

There may be things that all of us can do in little personal drog abatement programs to change social situations that create drinking fog. We can accept the right to drink and the right to abstain as equal rights. The host who serves alcohol can easily provide non-alcoholic beverages for those who choose to abstain. This should be done in a casual way that shows the host to be concerned about which choice is made.

People in drinking situations can respect the rights of individuals to set their own limits. No one should be urged to have another drink after he indicates he does not want more. Pressures to drink can be eliminated without loss to anyone.

There may be some value in trying to show compassion for the person who drinks too much. It is quite confusing to see people laughing at you when you drink too much.

Controversial problems can often be solved by finding new common goals or even new common enemies. Intoxication, alcohol-related accidents, alcoholism, and unrestrained release of pent-up feelings provide a common enemy for both the drinkers and the non-drinkers.

Drog abatement programs should face only the inertia of the status quo as obstacles and they should find a number of powerful allies in a new alliance for a new common goal.

Recreational and Other Activities

Recreational and diversional activities scheduled weekly include: an entertainment movie, outdoor recreation, a trip to the gymnasium, and music therapy. Patients may go once a week to the occupational therapy department to buy materials for making rugs. They may spend up to $5.00 per week at the Canteen and orders are taken weekly.

Patients spend their free time on the wards making rugs, playing ping pong, reading, writing letters, playing cards, watching television, and drinking coffee in the "coffee room." They put on their own "talent shows" and musical "jam sessions." There is a piano on the ward and other musical instruments may be borrowed from music therapy.

Patients may also attend Sunday morning Chapel Services. Personal counseling by the Chaplain is available.

What Treatment Can Accomplish

On the surface, Dorothea Dix's alcoholic patients are generally dissatisfied with being put out of circulation and literally locked up for thirty days. Along with this dissatisfaction goes denial of the **"reason why I'm here."** The patient may have been almost dead when he came in but, a week later, when he is feeling and looking better, he cannot conceptualize his situation in terms of anything being wrong with him. If there is anything wrong, the thing that is wrong is that **"he is here."** Treatment can first help the patient clarify in his mind what brings him to the hospital at this point. Then, hopefully, it can help him to understand what his difficulties are and what he can do about them in the hospital and on the outside. It can impress upon him the fact that his difficulties have been building up over an extended period of time and encourage him to **"take a second look"** at his family and environmental problems. And, even though the patient does not accept the fact that he is an alcoholic right away, it can give him basic information about alcoholism and its treatment to fall back on if, at sometime in the future, the patient **"does, in fact, find himself involved in alcoholism."**

A feature designed to help you keep posted on developments in the field of alcoholism.

RALEIGH: On January 22 the ARP's Raleigh offices moved from 216 North Dawson Street to 10 South McDowell Street. The post office box and telephone numbers will remain the same.

GARDEN CITY, LONG ISLAND, NEW YORK: The executive committee of the North American Association of Alcoholism Programs met in Garden City the week of December 6. One of the primary subjects discussed was the establishment of and plans for the new NAAAP central office in Washington, D. C. The committee met with representatives of General Service Headquarters of Alcoholics Anonymous and the executive staff of the National Council on Alcoholism. Representing the ARP at the meeting was Dr. Norbert Kelly.

NEW BERN: On January 15 in New Bern, Dr. Norman Desrosiers, acting medical director of the Alcoholic Rehabilitation Center at Butner, addressed the Eastern section of the State Nurses Association. Dr. Desrosiers' topic was "Treating the Alcoholic."

WILMINGTON: Dr. Norbert Kelly was guest speaker at a meeting of the Wilmington Industrial Management Club on January 14. The following day, he was the luncheon speaker at a meeting of the Employer-Employee Relations Committee of the Wilmington Rotary Club.

ATHENS, GEORGIA: The third session of the Southeastern School of Alcohol Studies will be held at the Center for Continuing Education at the University of Georgia in Athens, August 11-16, 1963. The school was organized to help meet the needs of professional and non-professional persons in the Southeastern region who are seeking a better understanding of the many problems relating to alcohol and alcoholism. The school endeavors to impart to its students factual, scientific information and enhance knowledge, understanding and acquired techniques. The faculty will be composed of some of the country's outstanding authorities in the field of alcoholism, the majority of whom are presently employed in either the area of instruction, community programming or in the rehabilitation of the alcoholic.

CHAPEL HILL, N. C.: A Summer School of Alcohol Studies for professional personnel interested or working in the field of alcoholism will be held at the University of North Carolina in Chapel Hill June 9-14. Sponsors for the week's activities will be the U. N. C. Department of Health Education in the School of Public Health, where the sessions will be held; the Alcoholism Programs of North Carolina and the N. C. Alcoholic Rehabilitation Program.

Lecturers and workshop leaders will include many outstanding persons

in the field of alcoholism throughout North Carolina. Among the lecturers will be Dr. Fred Ellis, associate professor of pharmacology in the University of North Carolina School of Medicine; Ernest Campbell, Ph.D., professor of sociology at the University of North Carolina; George Maddox, Ph.D., professor of sociology at Duke University; Dr. John Ewing, head of the psychiatry department at U.N.C.; Joseph Sills, member of the staff of the University School of Public Health; and Norbert L. Kelly, Ph.D., associate director of the ARP.

Other persons who will participate in the school as workshop leaders and panelists include Dr. Harris Evans, director of the Alcoholic and Drug Addiction Service at Dorothea Dix Hospital; Roberta Lytle, psychiatric social worker at the Alcoholic Rehabilitation Center at Butner; Dr. Norman Desrosiers, acting medical director of the Center; Reverend Joseph Kellermann, director of the Charlotte Council on Alcoholism; Dr. Thomas Jones, a physician and staff member of Watts Hospital in Durham and board member of the Durham Council on Alcoholism; and George Adams, educational director of the ARP.

The curriculum of the week's course will include a study of the nature of alcohol and problems associated with its use; problems of the alcoholic and his family; the symptomatology and treatment of alcoholism, workshops on professional needs in alcoholism treatment and education, and films and discussions.

Cost of the week's course will be $76.00, including room, board and tuition.

Anyone desiring more information on the Summer School should contact the School of Public Health at the University of North Carolina in Chapel Hill.

RALEIGH: Raleigh will be the scene of a statewide institute on the "Homeless Alcoholic in North Carolina" on February 13 and 14. The meeting, to take place in the Church of the Good Shepherd, will be sponsored by the Alcoholism Programs of North Carolina, the National and N. C. Associations of Flynn Christian Fellowship Houses, the N. C. Board of Paroles, the State Probation Commission, the N. C. Department of Prisons and the NCARP. Several outstanding persons in the field of alcoholism will be among the guest speakers at the two-day meeting. Dr. Earl Rubington, associate professor of sociology at the Rutgers Center of Alcohol Studies in New Brunswick, New Jersey and Arthur Pratt, Jr., president of the National Association of Flynn Christian Fellowship Houses, Inc. of Indianapolis, Indiana are among the out-of-state speakers. The two-day program will include an address by Dr. Rubington, a panel presentation on a homeless alcoholic before the judge, on probation and on parole, by city and state law enforcement personnel; a dinner meeting featuring a talk on "Psychiatric Aspects of the Homeless Alcoholic" by Dr. Norman Desrosiers, acting medical director of the Alcoholic Rehabilitation Center at Butner; a panel discussion on the Flynn Christian Fellowship Houses and the homeless alcoholic by officers of the National Association; and a discussion on the homeless alcoholic in prison by staff members of the alcoholic rehabilitation division of the N. C. Prison Deaprtment.

DURHAM, N. C.: The 11th annual Presbyterian School of Christian Growth for members of the seven Presbyterian churches in the Durham area will be held January 27-31 at the Trinity Avenue Presbyterian Church. The school will include a Bible study course for adults and a class on the problems of alcoholism. ARP education director George Adams will be the principal leader of the class on alcoholism problems and will speak on "Teen-age Drinking: Attitudes and Practices." The associate director of the ARP, Dr. Norbert L. Kelly, will also participate in the training session and will speak on "Youth Culture as Related to Alcohol."

THIS IS A.A.

CONTINUED FROM PAGE 9

I do feel some purpose in it. And now when I go through one of my low spells, and I suppose all of us have them, and I sometimes think, "What's the use? Is there any difference, really—except that I'm sober?" And then I stop and think, "except that you're sober!" And I remember that when I came into A. A. sobriety was the only thing in the world I even hoped to find here. Everything else, and there's been so much! I found out that I was able to hold a job, that I was able to make deep and important friendships, that I was able to be happy in my family life and to enjoy the well-being of my husband and my children. I discovered a new joy in the practice of my religion. All of this—so much—that my cup almost runs over. All of this, when all I was looking for was sobriety. And if I really remembered what it was like when I didn't have it, all I had to do was to remember those last two terrible years before I came into A. A.—when I drank alone late at night after everybody was in bed—when I felt that I was alone in the world and nobody cared. And I remember that even then I used to think that surely there must be some purpose in this—surely it must be leading somewhere—surely I must be looking for something that's missing from my life. And I know that even in my drunken confusion I was right about that. I was looking for something and I found it. I was looking for A. A.

Now I'm proud of this story that I just told you. I spent years trying to forget it and others like it, but I know now that I must never forget, lest I forget to be grateful to God for helping me to find A.A., and lest I forget to be grateful to A. A. for helping me to find my life.

HOMELESS MAN

CONTINUED FROM PAGE 24

this context that he drinks to excess. As such, admittedly through his own behavior, he is the least respected member of the community and his treatment by the community has at best been negative and expedient.

In all fairness, however, it should be pointed out that in the last four years certain pioneer rehabilitation efforts have been started. These include the establishment of Half-Way Houses to bridge the gap between institutional and Skid Row living on one hand and independent existence in the community on the other, and the demonstration project on the rehabilitation of Skid Row alcoholic men conducted by the Volunteers of America of Los Angeles in Los Angeles.

On the whole, however, the homeless man has never attained or else has lost the necessary respect and sense of human dignity on which any successful program of treatment and rehabilitation must be based. He is captive in a sequence of lack or loss of self-esteem, producing behavior which causes him to be further disesteemed. Thus, any therapeutic program directed to the homeless man must interrupt this cycle in the individual.

But my orientation is guided by the statement, "It is better to prevent than to salvage and repair." This means that research must proceed on the level of determining what social and economic factors in American society contribute to the development of Skid Row areas and the phenomenon of homelessness in individuals. Unfortunately, the first question can be answered only in terms of speculation, whereas we have more empirical data relating to socioeconomic correlates of homelessness in individual cases.

Currently in North Carolina there are sixteen

LOCAL PROGRAMS ON ALCOHOLISM

ASHEVILLE—

Citizens' Committee on Alcoholism
Dr. C. D. Thomas
Western N. C. Sanatorium
Black Mountain, N. C.

Educational Division, Board of Alcohol Control, West Wing,
Parkway Office Building
Don Dancy, Educational Director
Phone: ALpine 3-7567

CHAPEL HILL—

Orange County Council on Alcoholism
102 Laurel Hill Rd.
Dr. D. D. Carroll, Director

CHARLOTTE—

Charlotte Council on Alcoholism
1125 East Morehead Street
Rev. Joseph Kellerman, Director
William Hales, Associate Director
Phone: FRanklin 5-5521

DURHAM—

Durham Council on Alcoholism
602 Snow Building
Mrs. Olga Davis, Executive Director — Phone: 682-5227

GOLDSBORO—

Wayne Council on Alcoholism
P. O. Box 1320 — Phone: 734-0541
A. T. Griffin, Jr., Executive Director

GREENSBORO—

Greensboro Council on Alcoholism
216 W. Market St., Room 206 Irvin Arcade—Phone: 275-6471
Worth Williams, Executive Director

HENDERSON—

Vance County Program on Alcoholism—Phone: GEneva 8-3274 or GEneva 8-4702
Dr. J. N. Needham, Director
2035 Raleigh Road

JAMESTOWN—

Alcohol Education Center
P. O. Box 348
Ben Garner, Director

LAURINBURG

Scotland County Citizens Committee on Alcoholism
308 State Bank Building—
P. O. Box 1229
M. L. Walters, Executive Secretary — Phone 276-2209

NEW BERN—

Craven County Council on Alcoholism, Inc.
409½ Broad Street—P. O. Box 1466
Gray Wheeler, Executive Secretary — Phone: 637-5719

NEWTON—

Educational Division, Catawba County ABC Board
Rev. R. P. Sieving, 130 Pinehurst Lane — Phone: INgersoll 4-3400

REIDSVILLE—

Rockingham County Committee on Alcoholism
225 West Morehead Street,
P. O. Box 355
Mrs. Anne Wall, Executive Secretary—Phone: DIckens 9-4369

SALISBURY—

Educational Division Rowan County ABC Board, P. O. Box 114
Peter Cooper, Director
Phone: 633-1641

SOUTHERN PINES—

Moore County Alcoholic Education Committee, P. O. Box 1098
Rev. Martin Caldwell, Director
Phone: OXford 2-3171

WILMINGTON—

New Hanover County Council on Alcoholism, 316 Insurance Building
Mrs. Margaret Davis, Executive Secretary—Phone: 736-7732

WINSTON-SALEM—

Alcoholism Program of Forsyth County
802 O'Hanlon Bldg., 105 W. 4th St.
Marshall C. Abee, Executive Director — Phone: PArk 5-5359

OUT-PATIENT SERVICES

FOR

ALCOHOLICS AND THEIR FAMILIES

ARE PROVIDED BY THE FOLLOWING

MENTAL HEALTH FACILITIES

Competent Help Is Available At The Local Level

Mental Health Center of Western North Carolina, Inc.
415 City Hall
Asheville, N. C.
Phone: ALpine 4-2331

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
Chapel Hill, N. C.
Phone: 942-4131, Extension 336

Mental Health Center of Charlotte and Mecklenburg County, Inc.
1200 Blythe Blvd.
Charlotte 3, N. C.
Phone: FRanklin 5-8861

Cabarrus County Health Department
Concord, N. C.
Phone: STate 2-4121

Cumberland County Guidance Center
Cape Fear Valley Hospital
Fayetteville, N. C.
Phone: HUdson 4-8123

Gaston County Health Department
Gastonia, N. C.
Phone: UNiversity 4-4331

Guilford County Mental Health Center
300 East Northwood Street
Greensboro, N. C.
Phone: BRoadway 3-9426

Pitt County Mental Health Clinic
Pitt County Health Department
P. O. Box 584
Greenville, N. C.
Phone: PLaza 2-7151

Guilford County Mental Health Center
936 Montlieu Avenue
High Point, N. C.
Phone: 9929

Dorothea Dix Alcoholic Rehabilitation Service and Out-Patient Clinic
South Boylan Ave., Raleigh, N. C.
Mrs. Dorothy Ferrell, Psychiatric Social worker—Phone: TEmple 2-7581; Ext. 421

Mental Health Center of Raleigh and Wake County, Inc.
615 Wills Forest Road
Raleigh, N. C.
Phone: TEmple 4-6484

Rowan County Mental Health Clinic
Community Building
Main and Council Streets
Salisbury, N. C.
Phone: MElrose 3-3616

Cleveland County Mental Health Clinic
409 East Marion St.
Shelby, N. C.

Haywood County Mental Health Center
Haywood County Health Department
Waynesville, N. C.
Phone: GLendale 6-3542

Mental Health Center of Wilmington and New Hanover County
1013 Rankin Street
Wilmington, N. C.
Phone: ROger 2-8294

Wilson County Mental Health Clinic
Encas Rural Station
Wilson, N. C.
Phone: 237-2239

Forsyth County Program On Alcoholism
802 O'Hanlon Bldg.,
105 W. 4th St.
Winston-Salem, N. C.
Phone: PArk 5-5359

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bi-monthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department. Please request films as far in advance as possible and state second and third choices.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Displays—primarily for local public libraries; also available to school librarians and principals. All requests should be made through local public library to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
P. O. Box 9494
Raleigh, N. C.

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Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

Index of Inventory

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The Center is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the professional staff, educational films, individual consultations with staff members, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the medical director, a psychiatric social worker, a chaplain and admitting officer, a vocational rehabilitation counselor, an activities director, and a full attendant staff.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment in response to written or telephone request to the Medical Director of the Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment. All appointments must be confirmed by mail and should preferably be made by the patient's physician or by other professional personnel in the patient's community, for example, alcoholism information center personnel.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Services Agency, and a complete medical history, compiled by the patient's family physician, are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission.

4. Sign a letter-statement requesting voluntary admission at the time of admission.

It is especially important that patients applying for admission have a thorough medical examination and be in good physical condition at the time of their admission. The Center is not a hospital or a sobering up facility and patients desiring admission should have been sober for at least seventy-two hours and should not be exhibiting withdrawal symptoms. There are no facilities provided at the Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Days

Wednesday, Thursday and Friday during the morning and afternoon. Patients may have visitors after they've been at the Center for 2 weeks. Visiting hours are from 1:00 - 4:00 P. M. on Saturday and Sunday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

NORBERT L. KELLY, Ph.D.
Associate Director

NORMAN DESROSIERS, M.D.
Acting Medical Director

GEORGE H. ADAMS
Educational Director

INVENTORY

VOLUME 12 NUMBER 6

MARCH-APRIL, 1963

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices 10 S. McDowell St., Raleigh, North Carolina.

This journal is printed as a public information service. Persons desiring a place on the free mailing list must send in a written request, with the exception that *new* requests from *individuals* residing outside North Carolina can no longer be accepted. The views expressed in articles published in *Inventory* are those of the authors and not necessarily those of the NCARP. Manuscripts are invited with understanding that no fees can be paid.

Write: INVENTORY, P. O. Box 9494, Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

ONE of the oldest controversies in the medical literature on alcoholism has centered around the question whether and to what extent problem drinkers benefit from being confined for a spell in a hospital or some other type of institution devoted to treatment and rehabilitation.

No one disagrees that the acutely intoxicated or delirious individual usually requires emergency care in a hospital. But does the chronic phase of the disease, the alcoholism itself, the inability to control drinking, respond better to in-patient or out-patient management?

In favor of the confinement technique is E. H. Mitchell (Washington, D. C. Hospital Center) who believes that most problem drinkers recover more readily in a protected therapeutic environment designed for their special needs. The out-patient clinic, he argues, may be unable to deal effectively with the patient who cannot abstain from drinking or who is still recuperating from a period of prolonged excess. In an institution designed for alcoholics, there is the additional advantage that the patient is continuously exposed to a kind of informal "group therapy" with other problem drinkers. According to experience in a number of hospitals, this extra-curricular learning may carry as much weight as the formal treatment program. During the period of confinement the individual is getting, in effect, 24-hour-a-day therapy on every possible level. No out-patient program can offer him more than about three hours weekly—a relatively limited opportunity where total re-education is necessary.

Mitchell recognizes some disadvantage inherent in the "protected therapeutic environment." Some patients, he notes, use the hospital as a further retreat from reality—a cushion bewteen themselves and the world, rather than a bridge to a healthier life. This, of course, has been the spearhead of the opposition's attack. "In the last analysis the alcoholic must be able to function as a member of organized society, and to remain abstinent from alcohol within the environment of that society, if his alcoholism is to be arrested." These are the words of F. E. Lawrence (Indiana Division of Mental Health) who believes that, while it is sometimes desirable and even essential that the alcoholic be cared for in the hospital, the definite treatment of the vast majority should occur at the out-patient level. Frequently, he argues, the problem drinker is maintaining only a very tenuous adjustment to the realities;

IN-PATIENT VERSUS OUT-PATIENT TREATMENT OF ALCOHOLICS

● *In-patient versus out-patient treatment should be handled individually.*

even this can be broken by a short period of hospitalization and may be extremely hard to restore. Protracted in-patient care encourages an increasingly dependent state, merely postponing and making more difficult the inevitable moment when the person must face the world again. As a general rule, then, if there are no pressing medical indications for hospital care, Lawrence urges that treatment should begin at the out-patient level. Only those alcoholics should be hospitalized who have failed to improve after intensive out-patient treatment or who, in the course of such treatment, develop new problems which make care in a hospital essential. The decision should not be made without carefully considering the person's social, economic and psychiatric needs as well as medical symptoms.

In agreement with this view is the opinion of A. L. Ruprecht (Seattle, Washington) that few alcoholics require a hospital stay unless there is a complicating illness. On the basis of experience in a day-care program he states that withdrawal symptoms, vitamin deficiencies—even hallucinosis and severe vomiting—can be treated extramurally if the patient comes daily to a clinic for a week or so. An out-patient facility not only suffices for the average medical problems "but also permits the channeling of many forces that favor recovery"—for example, showing the patient how active a part he must play in his own treatment. "Going to a clinic several days in succession is very different from admission to a hospital where a variety of people meet every personal need."

An entirely new issue, however, is raised by J. Clancy (Alcohol Clinic, State University of Iowa). If the patient has lost control of his drinking, Clancy argues, it is possible that organic brain damage may have occurred. Since a brain-damaged individual cannot be expected to impose effective controls, enforced control through hospitalization must be instituted. In such cases, "Re-educative and supportive measures, combined with Alcoholics Anonymous affiliation while the patient is still in the hospital, seem to offer the best hope for successful rehabilitation."

All the commentators appear to agree that although the advent and effectiveness of the tranquilizing drugs have made the alcoholic more easy to treat on an out-patient basis than formerly, there will always be cases which demand intramural confinement. Where the risk of suicide is apparent, for instance, hospital care is imperative. If the patient's home life is such that it counteracts the effects of therapy, or if there actually is no home, out-patient care will hardly suffice. If loss of control over drinking has engulfed the individual totally, he may require a period of insulation.

It seems unlikely that the time will ever come when adequate in-patient facilities of a specialized sort will be available for more than a fraction of those who desperately need them. Most of the facilities which do exist are beyond the financial means of the vast majority of problem drinkers. The arguments of those who favor hospitalization will therefore remain largely theoretical, however worthy their goal.

As is often the case, the only logical conclusion from weighing both sides of the argument is that the matter of in-patient versus out-patient treatment must always be handled individually. The personality of the patient and his circumstances will be the decisive factors. One point of general agreement is that the appropriate treatment in the individual case would probably eliminate many therapeutic failures.

Senior Nursing Project

I am a senior student in nursing and am writing my senior project on the "Role of the Nurse in Alcoholic Rehabilitation" — teaching, understanding, etc. I would appreciate any booklets or information you might be able to send me on the subject. I am also interested in knowing about the hospitals available for the rehabilitation of the alcoholic and the role of the family and the alcoholic.

Clara Kenney
AMH School of Nursing
Auburn, New York

Gratitude Expressed

It is hard to express my gratitude for the continual arrival of *Inventory*. It is of the greatest help to me in my work here for I find in it so many informative and helpful articles that I am able to use in working out programs of therapy for the men in residence here. A number of publications concerning alcoholism come to my desk, and many of them are useful and worthwhile, but *Inventory* gives me more than any of the others. You and your authors are greatly to be congratulated and I hope that you will keep me on your mailing list.

Rev. K. L. Sandercock, Director
The Henry Ohlhoff House
San Francisco, California

Request From Student

I am in graduate school at U.N.C. working on my Doctorate in counseling and guidance. I would appreciate it if you would send me your current issue of *Inventory* and place my name on your mailing list for future copies.

Walter R. Parker, Jr.
Chapel Hill, N. C.

Useful in Group Therapy

We have used the articles in your publication, *Inventory,* in some of our group therapy sessions and they have elicited a great deal of interest. We would like to receive two or three copies of this publication, if possible. We believe your journal is a most excellent publication.

James Ray
Alcoholism Rehabilitation
Center Coordinator
Grand Rapids-Kent County
Health Departments
Grand Rapids, Michigan

Help For An Alcoholic

I have an alcoholic problem, and since I admit that I am an alcoholic and want all of the help that I can get on the subject, I am writing to ask you to send me your bi-monthly magazine, *Inventory,* and all of the literature you can send me concerning alcoholism. Anything concerning the family problems in alcoholism will be greatly appreciated.

Anonymous
Waynesville, N. C.

Social Worker Writes

I am a social worker and have been so interested and pleased to see your valuable magazine for the first time in December, 1962. I will appreciate your sending me a copy of that issue and adding me to your mailing list.

Frances G. Pfohl
Greensboro, N. C.

VOL. 12 NO. 6 INVENTORY MARCH-APRIL, 1963

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

Group Therapy With Alcoholics

BY DR. TH. KJOLSTAD

MEDICAL DIRECTOR
FOR THE
TREATMENT OF ALCOHOLISM
IN NORWAY

The alcoholic in individual therapy can easily dismiss postulates of the doctor as irrelevant but, in group therapy, he cannot so easily do away with comments by fellow patients about his situation or behavior.

Published by permission of the International Bureau Against Alcoholism, Case Gare 49, Lausanne, Switzerland, *Group Therapy With Alcoholics* was presented by the author at the 8th European Institute on the Prevention and Treatment of Alcoholism held at Warsaw, Poland in August of 1962.

A GROUP in our view is constituted when two or more persons communicate with each other, verbally or otherwise, and the persons concerned react to the communication one way or another. The group may be formed voluntarily or as a result of some kind of pressure. What happens in the group is to some extent dependent on outer circumstances, but it is chiefly determined by the readiness of the participants to communicate. Whether a group is therapeutic or not, therefore, depends upon its composition. However, therapeutic results may be attained in a group whether this is intended by the members or not and may even occur, in special circumstances, in spite of the wish of the group.

Although communication in groups and reaction to it has taken place since man could make himself understood, organized use of groups for therapeutic ends is of fairly recent date. Medicine, far into this century, has treated the patient as a solitary specimen. It is only recently that we have recognized that the person in need of treatment is not just the patient himself but, also, the patient in his milieu or as a member of society. When we try to rehabilitate a patient, it is not enough to make him able to function separately—for example, in a hospital setting. It is also necessary to help him to take part in the community to which he must return after treatment is concluded. When this was realized, the step to organized group therapy was not far and was tried very soon.

There is a vast experience of different techniques recorded in the literature as a result of different

methods of group therapy which have been tried during the past thirty years. As it is to be expected, there has been quite a struggle between the different authors as to which method is preferable and, at the moment, one cannot say the issue is settled. It is very probable that different techniques will give good results with different patients and, also, that different group leaders will get the same results with different techniques applied to the same kind of patients.

It is, for instance, unquestionable that the personality of the group leader is very much related to results and therefore that the group leader should develop or grow in his own technique. This does not mean that the group leader must become stereotyped; he has to mold himself to the group concerned. The aim is not to form the group in the leader's image, but to bring the group's positive elements forward even if they do not correspond to the leader's idea of what the "right" pattern is. A good group leader, therefore, must be very liberal and flexible but, at the same time, able to put emphasis on the important items of discussion and, in a subtile way, rule out all the small talk as not desirable.

There are many pitfalls for the group leader to fall into and the more unwilling the group is to cooperate in a positive way, the more pitfalls there are.

The average neurotic who seeks help for his anxieties or compulsions will be positively motivated to therapy in the first instance. Some neurotics will, during treatment, be scared away and stop therapy as they find their "securities" are dissolved, but most of them will persist when their difficulties are explained to them and they are given support through this phase. In a way something in the nature of their illness compels them to go through with treatment even if it is painful for them.

The neurotic will come to therapy with his symptoms and is usually grateful when he is taught what their meaning and origins are. Except for the "compensation-neurotic," he will be happy at the prospect of being relieved of these symptoms and by understanding their cause. What is most important, he wants to learn how to escape situations that might reactivate his symptoms. In this way, the neurotic can be compared to the patient who seeks treatment of a bad cough and is told that his cough is caused by tuberculosis. This is, of course, frightening to the patient, but usually he will go through with the proper treatment when he understands the necessity.

Certain Danger

Group therapy with neurotics is usually very gratifying to the group leader. However, there is a certain danger in "plunging too deep" with neurotic groups in that the group activity may raise emotions that are too strong to handle, both for the patient and the group leader. The latter, therefore, will often have to act in a restrictive way, since the aptients, being unaware of the dangers involved, may try to quicken the pace.

Turning now to the alcoholic patient, how does he react to treatment and, especially, to group treatment? The average alcoholic we meet as therapists is usually not well informed about his illness, and some of his symptoms will be a hindrance to him in seeking treatment. The most striking features in the picture are anxiety and isolation, both socially and in time.

The alcoholic will be driven by guilt feelings which either make him

overtly anxious or cause him to overcompensate and behave arrogantly. Underneath the arrogance which makes him repulsive to his environment, the alcoholic is constantly on the lookout for sympathy and understanding and, at the same time, is very sensitive to the smallest rebuff. He feels hurt on the smallest provocation and reacts to this with total withdrawal.

Socially, he will feel himself as an outcast, even more than actually is the case. The only place he feels he belongs is with other alcoholics and he only feels this when he is drinking. The alcoholic, as soon as he leaves off alcohol, is floating in no man's land and dares not risk contact with anyone except superficially. He is mentally and socially isolated from his surroundings, partly as a result of his own anxiety and partly because of social misbehavior during his drinking periods. He will be on bad terms with his family and usually in difficulty over work, as he is unreliable in every way.

His withdrawal from everything makes him unrealistic in his outlook and he will usually misinterpret all attempts to help him. Since he only finds relief when he is drunk, his aim in drinking will usually not be to feel "high" but to keep the unbearable reality away. He drinks not to be "high" but to avoid becoming sober.

The alcoholic further isolates himself in time. He does not dare to look backward as this will reveal his personal tragedy. To look forward is only to look into disaster. By indulging, he can keep his consciousness within a very small space of time, usually only hours, and this permits him to fulfill the wants of the moment without regard to further consequences. If he is forced into sobriety, the alcoholic tends to divert himself with any kind of passive entertainment. Anything that can keep him from thinking is accepted as a means of escape from reality.

This is how we meet the alcoholic whether he comes to treatment as a voluntary or as a committed patient.

The average alcoholic seeking treatment does so because he understands that he can't go on as he is, or he is forced by circumstances, such as impending divorce or the danger or losing his job. He wants help for his problems and immediate relief from his symptoms. Rarely aware of how he is affected by alcohol, he will usually have very hazy ideas of how treatment can help him.

As a rule, the alcoholic will not accept that he can't drink with moderation, and will give a long list of reasons why he must drink. He regards circumstances as compelling factors and wants society to change in a way that will make it possible for him to stay sober. This is, of course, unrealistic, but from the alcoholic's isolated point of view, it is the only solution to his problems. He will usually think that if circumstances are changed, he will have no trouble drinking as other people do, in moderation.

The first step in treatment—explaining to the patient what his illness is and what can be done about it—will, therefore, be a disappointment to the alcoholic. He does not want to give up alcohol for a variety of reasons. Alcohol, for one thing, is his shield against reality and, further, to give up alcohol to most men means a degradation of themselves. To be a man means to stand up to one's liquor.

Individual treatment of alcoholics takes a lot of time, and asks for more patience than most people can afford. The therapist has to be very liberal at the outset and have cour-

age to carry on in spite of many failures. The alcoholic is seldom a grateful patient during therapy although he may turn into one after successful treatment.

There certainly are advantages in individual treatment of alcoholics, especially in the initial phases, but in the long run these advantages turn out to be difficulties. The alcoholic seen individually will readily enough cooperate in forming a superficially good patient—therapist relationship, but it will be lopsided. The patient will take what is given but usually not give anything. It turns out that the relationship is a dependence of the patient on the therapist. The patient will feel frustrated and deserted as soon as the therapist tries to do away with the dependency. This is, of course, not unique for the alcoholic patient, but it is more pronounced than with the usual neurotic patient. The alcoholic, like the neurotic, does not want to shoulder responsibility and face reality, but alcohol has helped him much further along the road from reality than the symptoms of the average nuerotic have carried him.

The breaking up of the relationship will, however, take place more often at the wish of the patient than by a realistic decision on the part of the therapist. The alcoholic will find that his needs are not being met by the therapist, not because of incompetence on the therapist's side, but because the patient does not realize what his real needs are. He will only accept treatment so far as it gives him immediate relief; he does not want to work through painful sessions where he must provide the material for discussion. If the therapist cannot give the patient ready-made solutions and advice about his difficulties, the patient will regard the therapist as a quack and find his own "solutions."

The alcoholic's isolated position is one of his chief problems and, in my opinion, individual therapy accentuates this isolation. The patient in the private interview is, and regards himself as, the only person who really matters. In this way he is encouraged in looking on himself as a very special case and his wishes as the only ones that deserve consideration.

Group therapy will meet the alcoholic's needs better than individual therapy, but this does not mean that the alcoholic will appreciate it right away. On the contrary, the alcoholic will realize very soon that group activity will destroy his shields against reality and, as a result, put up a lot of defense mechanisms. It is not so difficult for the alcoholic to dismiss the postulates of a doctor or psychologist as irrelevant. He will say that *they* are not alcoholics and, therefore, do not really know how it feels or what can be done. But, confronted with fellow patients, he cannot so easily dismiss their comments on his situation or his behavior.

The patient receives a double benefit if he can stand up to group activity and tolerate realistic thinking. First, he will find himself able to communicate with other people in a sober condition and on realistic grounds. His social isolation will break up. Further, his guilt feelings will be relieved in the community atmosphere and, thus, his anxiety reduced. By taking part in more constructive planning with other patients, his time-isolation will gradually be suspended, too. He will start thinking further ahead and be more able to tolerate immediate frustration for the sake of a more distant goal.

The group, however, has to go through different phases before these positive things happen and resistance is given up. Initially, the pa-

tients are passive and anxious and very curious. The first spontaneous activity will usually be the expression of aggression directed toward society in general, the family, the employer and, eventually, the institution and the group leader. If the group leader refuses to take a position of defense, this phase will pass fairly soon.

The next phase will probably be that the patients try to put the group leader in the role of teacher or expert. They bring up technical questions, usually of no importance to them, and turn to the leader for an authoritarian answer. They often flatter the group leader—for instance by degrading other officers—and many a group leader has lost his foothold in this phase.

As a third phase, we encounter patients who bring up personal, but superficial, problems and who, in telling about them, imply or add a ready-made solution. The "solution" will usually be worthless and the "problem" brought up will have little importance except as an excuse not to talk about other things.

These three phases will not always turn up in the same order, but every group will have to get through them before constructive discussion can take place. The most difficult time for the therapist will then arrive.

The therapist may have the impression that the group is well under way; it has worked through the phases he knows; but then, suddenly, all activity vanishes and he is left with a group that has no spontaneity left. The members just sit around smoking and making small talk under their breath, or look furtively into a book or a serial magazine.

When this happens, a group leader who has only dealt with neurotics will often despair, thinking that the patients do not really want to be treated. The more experienced group leader, however, will know that his patience is being put to a real test. His ability to turn small talk into important discussion without scaring the patients too much will be the tool required to get the group working again. The passive leader role will usually not work with alcoholics in this phase. They can "outsit" anyone with their cigarette-rolling and vacant smiles.

There is no general answer to how the group leader can get the ball rolling again, but I think every group leader must learn by his own mistakes and find his own modus operandi. The group leader is probably an important figure during this "critical phase" in a group with alcoholics. Before this phase and after it, however, he is of less importance—a fact which is not always understood by group leaders of an active or aggressive mind.

Sanatorium for Alcoholics

Bjornebekk Kursted is a sixty-bed sanatorium for alcoholics located some 35km southeast of Oslo. There is always a waiting list from September to April, and the sanatorium is often overloaded. The average age of the patients in 1961 was 35.5 years.

Ninety-eight per cent of the clients enter as volunteers in the formal sense but, as mentioned earlier, many, perhaps the majority, find their circumstances so pressing that they feel they have no choice but to try a cure. They accept treatment to please their wives or employers, not because they realize that they have an alcoholic problem needing treatment.

The remaining two per cent are not volunteers, but are committed for treatment by the local Sobriety Board. The commitment is usually for one year but treatment is, in fact, usually shorter since the medical director has power to discharge the pa-

tient at any time. Usually they are discharged after three or four months, but the discharge is conditional. That is to say, if the patient starts drinking again, he can be taken back for treatment by decision of the medical director, even against his own will, and can then be kept in the sanatorium up to one year. This way of forcing the patients back into treatment is not much used as such patients, in most cases, return on their own to resume treatment. On the whole, there are few runaways. Out of 253 patients treated in 1961, only 25 left without permission.

The sanatorium is a completely open institution, and the patients keep the keys to their own rooms. The wards consist of single and three-bedded rooms. The patients have limits as to how far they can go outside the grounds and are always supposed to be in for meals and for lights-out at 11:00 P.M. Once a month, they are granted leave for one to three days.

Treatment in the sanatorium is paid for by sick insurance funds. If the patient has a right to it, accordto the general rules, he will also have "sick money" as long as he stays in treatment. Alcoholism is treated like any other illness in this regard.

The staff consists of four full-time medical officers, of whom two qualify as psychiatrists, one psychologist and one social worker. The remainder, up to a number of 31, are work leaders and administrative and general workers. Staff meetings, lasting from 20 minutes to one hour, are held every morning.

The sanatorium is divided into six wards of eight to ten rooms plus one ward which is set apart for initial care and somatic illness.

The patients are expected to be at work at least six hours daily, and a certain pressure is put on them to this end. Work facilities are good, with a large farm and a work-shop. There is a lot of maintenance work for patients who are permanently or temporarily disabled.

The new patient is placed on the sick ward and stays there for three to four days, according to his condition, physical and mental. During this time, he is clinically examined and, when mentally clear enough, a social anamnesis is made by the social worker. One of the physicians then writes up a psychiatric history after examining the patient.

As soon as the patient is fit enough, he is put in a three-bedded room and allotted work. In choosing work, consideration is given to the patient's wishes as far as possible. After some time, each patient will, in turn, acquire the right to a single room. He is allowed two Norwegian kroner each working day as pocket money.

A day's schedule is as follows: Breakfast, 8:00 A.M.; working hours, 8:30-11:30 A.M.; lunch, 11:30 A.M.-1:00 P.M.; working hours, 1:00-4:30 P.M.; dinner, 5:15 P.M. The rest of the day may be devoted to recreational activities, such as playing cards, billiards, table tennis, television (restricted to ten hours a week), football and skiing, according to the season. Wednesday evening is set aside for a general meeting: either a discussion meeting with staff and patients, or a meeting with visiting groups, for instance, Alcoholics Anonymous.

Group treatment is considered the most important activity at Bjornebekk Kursted and all patients are expected to take part in it. In the beginning there was quite a lot of resistance to group therapy, but it has diminished. Now the majority of patients find it natural to attend groups, even though they sometimes reveal their resistance by the various

psychological escape methods in the actual group session.

We have been, and still are, in much doubt about the best way of applying group therapy in a setting like ours. A number of different approaches have been tried, and we have observed their advantages and disadvantages:

Group therapy as a voluntary and "free time" activity ensures that the members are really interested in group work and this makes such groups "easy going" and satisfying for the group leaders. On the other hand. the experience is that a lot of the volunteers desert the group as soon as the discussion tends to become personal and make demands on them. A further difficulty with volunteer groups is that a big minority of even a majority of the patients never join a group at all. We have, therefore, come to the conclusion that group membership must be compulsory for all patients.

Composition of Groups

Composition of the groups has also given much food for thought. We have tried different ways of selection—for instance, intelligence levels, age, social-economic standards, stage of treatment—and found that none of them give good results overall. Lately, we have settled for a way of selection that will be described later.

The size of the group is, in our experience, a very important factor. We started out with groups of ten to twelve patients but found that, with so many, there would usually be three to four patients who daydreamed throughout the session and did not really participate in the activity. After some time, in which we tried by more authoritarian activity from the group leader to activate all members, we cut the size of the group to six. This has been an improvement as to active participation but it may, of course, make the group go "stale" from time to time.

The role of the group leader is a much debated subject, and different leader-techniques have their advocates. As mentioned earlier, I believe each group leader has to find his own method. Generally, it can be stated that the less experienced a group leader is, the more he must rely on authoritarian methods. When he becomes more secure in his position, he can stand up to more aggression and act in a more liberal and permissive way. It is probable that there are inborn qualities that make the best group leader and that all the theory in the world cannot make a good group leader out of a person who is not fairly mature and secure himself. And even the best equipped worker has to go through a series of mistakes before he gains insight enough to be a *good group leader.*

The theory of the group leader as a very passive figure will meet with success in group therapy with patients who have a good insight into their symptoms and are really willing to give themselves away. As mentioned earlier this is not usually the trend of the alcoholic's mind. A more directive leadership is, therefore, necessary in certain phases of treatment. I think the group leader must be able to change his own attitude not only in different groups, but also at different times in the same group.

At the moment the usual procedure in group work at Bjornebekk Kursted is as follows:

As soon as the patient is fit enough to attend, he is put in a group with other new patients known as the information group. The patient will meet for one hour three times in the course of a week and be given information about alcohol, its pharmacological and psychological action,

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A feature designed to help you keep posted on developments in the field of alcoholism.

RALEIGH: On April 6, NCARP publications editor Lillian Wilson became Mrs. James Pike. Her fellow workers wish her well in her new career as wife and homemaker. We're glad to report that she's not leaving Raleigh but will remain with us as editor of INVENTORY and head of the publications department.

GREENSBORO: Worth Williams, executive director of the Greensboro Council on Alcoholism, has announced that the Council will sponsor its annual Alcohol Education Week April 29 - May 3. Most of the week's events will be held at the home economics building on the campus of the Woman's College of the University of North Carolina. Special emphasis will be placed on alcoholism and industry and the program will include a workshop for foremen and supervisors and an institute for personnel directors. In addition, there will be an institute for practical nurses and talks before two assemblies of students at local high schools.

NEW BERN: New Bern will be the scene of the semi-annual meeting of the Alcoholism Programs of North Carolina on May 9 and 10. For the first time, the meeting will be a two-day affair. Besides the usual business and program, the meeting will feature alcohol education workshops. Hosts for the occasion will be members of the Craven County Council on Alcoholism headed by executive secretary Gray Wheeler.

THE CHURCH AND THE ALCOHOLIC: The Board of Christian Social Concerns of the North Carolina Conference of the Methodist Church sponsored three tri-district public rallies and pastors' conferences on "The Church and the Alcoholic" in three North Carolina cities in March. Dr. Thomas J. Shipp, pastor of Lovers Lane Methodist Church in Dallas, Texas and widely recognized as an outstanding leader in counseling and helping alcoholics, spoke at the Hay Street Methodist Church in Fayetteville on March 12; at Duke Memorial Methodist Church in Durham on March 13; and at Jarvis Memorial Methodist Church in Greenville on March 14. His topic for the pastors' conferences was "The Redemptive Role of the Pastor and Church to Drinking Persons." It was followed by a question and answer session. Pastors of all denominations were invited to attend.

At the public rallies in the evening Dr. Shipp spoke on "The Church and the Alcoholic." Pastors, chairmen and members of Commissions on Christian Social Concerns, Church School teachers and officials, other professional persons who work with alcoholics, and laymen interested in the illness of alcoholism were invited to attend the rallies.

REIDSVILLE: Another Flynn Christian Fellowship House was opened recently in Reidsville. This home is the ninth to open its doors in North Carolina. It is located at 616 Montgomery Street and is managed by Mr. and Mrs. Harold Tadlock.

RALEIGH: NCARP associate director Dr. Norbert L. Kelly was a featured speaker at a conference on the development of local community councils on alcoholism held at Mississippi College in Clinton, Mississippi February 11-14. The conference was sponsored by the Hinds County Council on Alcoholism and the National Institute of Mental Health.

RALEIGH: The NCARP will sponsor four summer schools for teachers and prospective teachers this summer. Summer Studies on Facts About Alcohol will be held at North Carolina College in Durham June 11-21; at East Carolina College in Greenville June 18-28; at Winston-Salem Teachers College in Winston-Salem July 8-19 and at St. Andrews Presbyterian College in Laurinburg July 22-August 14. The course of study, which carries college credit, is designed to give those persons who attend a better understanding of the many problems—sociological, psychological, and physiological—which arise through the use and misuse of beverage alcohol. Lecturers for the summer sessions will include North Carolina's foremost authorities on the study of alcohol and problems related to it.

A. A. RETREAT: The Piedmont Diocese of the Episcopal Church of North Carolina has again made its facilities available for the 1963 A. A. retreat. The retreat will be held June 7, 8 and 9 at Vade Mecum near Hanging Rock State Park in the Sauer Mountains. The usual rich and full A. A. program will be scheduled.

CHARLOTTE: The Charlotte Council on Alcoholism sponsored a series of four lectures on alcohol and alcoholism especially for court and law enforcement officials during the month of February. The lectures, which were followed by group discussion, were held each Thursday during the month. Dr. Norbert Kelly delivered two lectures to the group—on February 7 and 28.

RALEIGH: Approximately 950 persons gathered in Raleigh on March 7 and 8 for the annual meeting of the North Carolina Mental Health Association, held this year in conjunction with the North Carolina Leadership Conference for community civic, governmental, industrial and educational leaders. A highlight of the meeting was a speech by Dr. William C. Menninger, president of the Menninger Foundation of Topeka, Kansas. Dr. Roy Menninger delivered the speech to delegates of the two groups and members of the North Carolina General Assembly for his father who was ill and unable to attend.

Speakers for the Mental Health Association meeting included Dr. William Sheeley, chief, General Practitioner Education Project, American Psychiatric Association, Washington, D. C.; Dr. Robert M. Martin, Jr., regional medical officer, United States Civil Service Commission, Atlanta, Georgia; Dr. Charles E. Smith, medical director, Bureau of Prisons, United States Department of Justice, Washington, D. C.; and Dr. Marvin E. Perkins, Commissioner of Mental Health Services, New York City.

Delegates to the Leadership Conference heard the Honorable Terry Sanford, Governor of North Carolina; Dr. Fillmore H. Sanford, consultant, Joint Commission on Mental Illness and Health, Austin, Texas; Mike Gorman, executive director of the National Committee Against Mental Illness, Washington, D. C.; and Phillip E. Ryan, executive director of the National Association For Mental Health, New York City, N. Y.

EDITORIAL

Alcoholism—
SICKNESS or CRIME?

AUTHORITIES on crime have asserted that punishment, per se, never rehabilitated a criminal and, further, is not even an effective deterrent to, or prevention of, crime. Acknowledgment of the truth in this claim is reflected in the increasingly more liberal probation and parole policies of our own state and new rehabilitative programs in prisons such as work release and alcoholic rehabilitation.

If punishment, per se, has so little positive effect in dealing with crime, how, then, can a supposedly enlightened society expect it to prevent or cure a sickness? There was a time in this country when the mentally ill were labeled witches and the rather severe punishment of public whippings or burning at the stake was administered. Later, they were locked up and treated like wild animals, not sick people. While such treatment seems inconceivable today, it perhaps can be understood in retrospect on the grounds of ignorance. Mental illness was feared; it was not understood; it was thought to be a manifestation of evil spirits or was attributed to some other superstition. With the accrual of knowledge and understanding, society's fear and superstitions waned, resulting first in more humane handling and finally, in medical, psychiatric and social treatment.

There is, however, no such absolution for society from responsibility in the present-day punishing of sick alcoholics. Alcoholism is a recognized illness. There is a wealth of useable knowledge about the illness of alcoholism and its treatment waiting to be applied by official legislative, judicial and law enforcement bodies, by the helping professions, and by individuals. Part of this knowledge indicates that the punishment of imprisonment being meted out wholesale to sick alcoholics, though not of the severe corporal variety administered to the mentally ill of the past, may be just as destructive to the individual.

Ideally, the public drunkenness offender should be recognized and dealt with as a public health, rather than criminal, problem. If force is necessary, let it be enforced treatment, not useless punishment. The same courts which remand public drunkenness offenders to prisons and jails could, if it were made legal, remand them to treatment centers instead. A precedent of enforced treatment has been established in

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BY THOMAS JONES, M.D.

This speech is reprinted by permission of the author, a Durham, N. C. general practitioner who has served as chairman of the Durham Council on Alcoholism and who devotes a large part of his time to working with alcoholics in his community. It was given at a meeting of the Colorado Bar Association.

Recognition of possible necessity for treatment of the sick will come as the designation of "patient" replaces that of "alleged offender."

The Alcoholic—
PATIENT or OFFENDER?

IT is ironical that early in the past decade the House of Delegates of the American Medical Association found it necessary to pass a resolution that alcoholism is an illness; that the alcoholic is a sick man; that it is the physician's obligation to treat him.

Amazing also is the fact that many of our great churches have in recent years taken a somewhat similar stand, acknowledging that while drinking may or may not be sinful and the alcoholic a sinner, at least he is a *sick* sinner and, as such, entitled to his chance for salvation.

Ministry and medicine thus in some measure have joined hands. There are reservations within, and between, the ranks of these two great disciplines. But they are agreed on the common purpose that the alcoholic individual is sick and needs treatment.

Now, in a truly daring and prodigious venture, the vigilant state of Colorado has proposed sound *legal* support, direction and procedure, to implement the containment of this critical public health problem, alcoholism. Do you know just what your great state is trying to do? Do you know the challenges and the heartbreaks that lie beyond the door that you are attempting to open? Do you realize the potential effect upon our culture?

First, an avalanche of private and public criticism may attempt to shake your faith in the feasibility and sincerity of this redirection of century-old legal procedure. Pressures of money and influence may be brought to bear that will eclipse those exerted for criminal offense. The bewailing of despoiled bondsmen may revive the need for a counterpart of that incredible wall in Jerusalem. A die-hard core of the uncompromisingly prejudiced, who believe the alcoholic to be totally derelict or sinful (and this includes many in the three major professions of law, ministry and medicine), may drag their feet. They may even obstruct with the fire or ice of their own conviction in all good faith.

May I, therefore, impress upon you that a prerequisite to the success of this total program is your thorough education, persuasive understanding and infinite patience to cope with seen and unforseen difficulties as they develop.

May I add also that invitation to, and integration with, an equally sensitized clergy will be as vitally important as the necessary inclusion of the medical role as this revolutionary socio-therapeutic act unfolds.

One additional thought in this vein may be suggested. It will be of infinite value that all concerned with this new approach learn, absorb and apply as earnestly as you can the Twelve suggested Steps and Traditions of Alcoholics Anonymous. For if your personal attitude and action in any area of concern for the alcoholic reflects consistently this faith and philosophy the success of this act is assured.

Either by unfathomed chance, by the sum of my own behavioral response and inquisitive interest, or simply by divine guidance, it has been my uncommon privilege and experience to share much in the company and care of alcoholic patients during the past fifteen years.

I would share with you now my offering in two parts. That it will be somewhat medically oriented is reflected by my own profession. If a spiritual tone is anywhere apparent, know that I acknowledge the need to submit to God's will in my own life. I also affirm that alcoholism is an illness in every sense of the word.

The first part of my offering is an abbreviated interpretation of the varied experiences that I, as a general practitioner, have had with alcoholic patients. The second part is some effort at suggestions that might in some small way influence your thinking at this time.

The alcoholic is sick physically, emotionally and spiritually. If you doubt this, sit with one in constant attendance through the first forty-eight dry hours after the last drink of an average week-or-longer continuous drunken spree. Nausea, dry heaves and vomiting, dehydration, wracking cough, abdication of personal care, incontinence, uncontrollable shakes, delirium and many other signs and findings spell the departure from normal health—or, sickness.

This acute situation, plus the oft-present possibility of injury or other acute medical need, make our response and responsibility imperative. The presence and exacerbation of possible chronic illness such as heart trouble, liver disease, tuberculosis or diabetes emphasizes this need. We have the means, the tools and the knowledge, to meet much of this need, and it would be difficult to withhold participation at this point.

The alcoholic is also emotionally sick. He is lonely and terrified—despised and rejected by his fellowmen. He has the emotional anguish of remorse unknown to other ills. Anxiety, resentment, fear, frustration, bitterness, guilt, suspicion, delusions and a bottomless sense of inferiority all, or in turn, haunt him. This emotional sickness invites our recognition of psychological need.

But to my mind, the greatest sickness of all is the alcoholic's spiritual defection. He feels he has lost God, or that God no longer cares for him. Believe me, he, of all men, is more acutely aware of his retreat and dereliction from personal spiritual duty and salvation by faith than any non-alcoholic could ever appreciate. He is sick—sick spiritually in his need for the dignity implicit in acceptance by his fellowmen and by his surrender to a personal God.

Over the years, a fellowship group has met one night a week in my office. Weekly visits to the county work house and prison farm have taken rewarding time. Innumerable case experiences, in home or hospital, with agitated or subdued patients in the process of drying out, have added their measure of understanding, and I feel that they have given me the perception to dare phase the alcoholic's need in three simple statements of fact as he voices them:

1. I'm sick. For God's sake, give me something to help me.

2. Nobody will listen to me. Nobody cares.

3. I can't pray, and God wouldn't hear me anyway.

These are the alcoholic's words. These constitute his self-appraisal, his self-reproach, his confession of need. This is also his revelation of unrelenting and unforgiving self-centeredness. It is also at the same time a plea for, and a clue to, our best possible course of action.

The medical need for treatment can be satisfied more or less if we doctors simply apply the treatment aids that are of commonplace knowledge and availability.

Listen and Accept

The second, or emotional need, is met by resources that offer fellowship—the sympathetic ear, the understanding heart of any who will listen and who will try earnestly to accept him fully as a human being in his need. Patrolman, bailiff, attorney, judge; church, A. A., club or retreat; doctor, hospital, clinic or institution; from perceptive companionship to empathetic psychiatrist; from all these, the alcoholic can derive satisfaction of sorts if we but recognize this emotional need.

The church, represented by both congregation and clergy, can do much to help with uncritical pastoral counseling. Inclusion of the alcoholic in church activities and emphasis that the church is a place of worship—not a place of judgmental self-righteousness will also help.

In my state of North Carolina, varied success has come through more uncritical acceptance of the alcoholic as a legitimate patient without reproach or rebuff from doctor or nurse. Hospital attitudes also are changing and are becoming more receptive. The North Carolina Alcoholic Rehabilitation Program with a unique treatment center for voluntary patients is doing much to increase the number of recoveries, and much to decrease the stigma and rejection formerly manifest. Seven, and possibly more, spiritual retreats enable the chronic alcoholic to work his way as he seeks his personal serenity in group fellowship.

Community councils on alcoholism, alcoholism information centers and, more recently, the Flynn Christian Fellowship Houses, are spreading across the state, helping through education and rehabilitation to influence a more positive approach to this problem.

The influence of Alcoholics Anonymous is everywhere and, in recent years, the establishment of A. A. groups in many of the state penal institutions has borne the fruit of remarkable recovery statistics, with improvement in the drinking patterns of many more noted as they return to their individual communities to take up again responsible social relationships and work.

Social and welfare agencies are more alert to the significance and value of early detection and treatment. Inter-agency appraisal and utilization of sources of information and treatment are widely effected.

There are also many mental health clinics, private and state psychiatric institutions, nursing homes and private hospitals which provide care for voluntary, and at times, involuntary, patients.

There follows now a recount of ideas, hopes and suggestions, with reasons and explanation, that make sense to me as I see them.

The alcoholic in any stage of intoxication may be realistically likened to the patient coming from under anaesthesia, either still in the operating room or somewhere between there and the recovery room or his

own room, in that he reacts to his awakening and suffering feelings or to the stimuli of his immediate surroundings as his disturbed senses receive them. His responses are not predictable, and the come-and-go nature of his distorted behavior-pattern mirrors fairly well his reaction to trust or distrust of those about him. To put it in another way, he will react with dependence and acquiescence to proffered gentleness and with more or less agitated rejection to abrupt, startling or determined use of force.

The concern of police or any restraining attendant is to get the alcoholic to his ultimate destination or place of detention and safety as duty and circumstance require.

The flight of an alcoholic from approaching force is hardly different from the efforts of a patient to escape doctor, nurse or attendant if his arousing, but foggy, mind interprets their attentions as painful or abrupt. The fight of an alcoholic with his "captors" is well-known by relatives and the medical profession who have witnessed mechanical restraint where force is threatening or handling is rough. This is a simple explanation of why so many cases of arrest for drunkenness also carry the charge of resisting an officer, attempted escape, or flight from arrest.

This is a plea for education of all concerned in the techniques of taking someone into truly protective custody. The attendants in the locked wards of mental institutions could give some revealing instruction in the actual performance of such shepherding or directing.

The ready bondsmen and the hurried habeas corpus release many helpless and relatively incompetent sick and partially anaesthetized alcoholics into the reality of an unsympathetic and threatening public. Often, there is a quick and tragic repetition of enactment of custody or injury to self or others because of the failure of the alcoholic's inhibitory and protective judgments or his discernment of the propriety of actions in a confusing world of people and machines.

Vengeance is born, so often, from misunderstanding and from remembered violences of the past, both physical and of psychic nature, including the subtle personality references, slights of character and the needling innuendoes of well-meaning or poorly-intentioned relatives and friends. Particularly true, and unusually tragic, is this when an alcoholic son turns in drunken violence upon a parent whose possessiveness, jealousy or rejection, real or imagined, have been a disturbing factor in the alcoholic's life.

Techniques of Custody

Techniques of containment and custody should be taught by the experienced, and learned by heart, *with heart*. Persuasion that understands the importance of attitude and approach often succeeds where violence can be met only with primitive, uncontrolled flight or fight. A steady, simple, gentle monotone of instruction is preferable to a threatening or emotional display of authority. Often, if the custodian would allow some freedom of movement by strategic, protective maneuvering, the bewildered or unwilling alcoholic would go along more willingly. A commanding hand on the shoulder or forceful grasping of the arm may only result in undesirable resistance.

That the still-intoxicated alcoholic should be kept in protective custody until fully aware of his surroundings and status and, further, that he should receive care until physically and symptomatically adequate to participate in the proceedings of his con-

cern should be accepted without question. This should preclude trial or review on a morning-after. This should also prohibit the release on bond or habeas corpus as well, unless the bondsman or the attorney is willing and prepared to take full and responsible personal, physical custody of the alcoholic until a hearing or directed disposition is effected. This alone might prevent some of the revolving-door performances of many of the well-known repeaters, familiar to all courts.

Medical aid and support should begin concurrently with the moment of custody. At this point, practical nursing supervision might be utilized under medical direction and responsibility with excellent results. Where medical schools are nearby, senior students, under the same supervision, could most profitably be secured at a nominal cost for service that would afford invaluable, on-the-spot training for a situation commonly expected to occur frequently in the experience of any doctor.

The military hospital principle that recovering patients help themselves as well as those they attend by a sympathetic understanding could also be applied. How the services of a recovering alcoholic thus employed, help both the sick and the recovering one when the inducement of trust and needed assistance stimulates a returning sense of self-respect, is an amazing revelation.

A daily fellowship briefing that includes assurance of the principles and purpose of custodial procedure and the expected hearing could be carried out in any area of containment. The participation here of volunteer A. A. members who can supply both genuine understanding and hope could have far-reaching benefit. Here, too, the alcoholic who is bewildered and aggrieved might be helped to a more realistic appraisal of his need for treatment.

The attorney, guardian ad litem, minister, kin or friendly visitor who is persuaded by the patient's attitude to fan the fires of confusion in the bewildered, or to sharpen the sense of grievance and hostility present in many, needs to be helped to see that this is but a deterrent to the success of treatment and creates obstruction to the efforts of those genuinely concerned with rehabilitation of the sick.

I hope that the courts will mellow traditional austerity with clinical understanding, as the medical board tempers clinical appraisal with both public and individual concern; yet, at the same time, may both judge and doctor maintain a sympathetic attitude, with dignity, that is not forbidding to the sick alcoholic.

May a uniform transition from adequate pre-hearing treatment and care to the final directed disposition follow an uninterrupted pattern and be quickly and smoothly effected.

Again, early individual A. A. sponsorship on a voluntary basis to continue until final discharge could be invaluable both to the court and to the patient. Here, solid early contacts could be made that would likely carry over to solid foundations in community life upon discharge.

As the designation of "patient" replaces that of "alleged offender," may the attitude of all concerned change from the critical supposition of possible guilt to the recognition of possible necessity for treatment of the sick.

All proper, private adjustments of individual need, particularly of family and employment, that arise from unexpected custody and/or commitment should be considered. Welfare agency supervision and care should be given where indicated for the reassurance of the patient. For there are many complexities which arise

under conditions of enforced confinement that can add immeasurably to the anxiety and concern of those so vulnerable to emotional self-torture. Care by one's personal physician during commitment might be encouraged where desired and practical.

Fellowship groups at all levels could be stimulated with the instructive value and leadership of volunteer A. A. help. The therapeutic value of interpersonal communication and ventilation in experienced hands has potential beyond all measure, particularly in this area of need. The magic of relationships on the coffee-pot level can repay far beyond expectation and initial cost.

Encouraged also are supportive visits by family members to the committed individual and to local Al-Anon and Alateen meetings for fellowship and the stimulating revelation that comes with better understanding of some of the basic emotional forces at work in the day by day interchange with the alcoholic. Rehabilitation and recovery is a "we" proposition, rarely ever a solitary problem or a simple one. Acceptance of the alcoholic by his family and friends as a sick individual is of utmost importance in the continuation of the treatment program far beyond the time of legal discharge. Visits by the alcoholic's employer, as proof of his sincere desire to have the alcoholic return to work after he has improved sufficiently to do so, will also prove helpful.

In my opinion, psychiatric participation in this program might best be found in advisory capacity only. Use of psychiatric help in active treatment should be reserved for the patient who is psychotic, either in temporary intoxication, or who is found to be so in the continuum treatment. It could be reserved for resistance to treatment in the non-psychotic as shown by failure to make progress under general medical and group therapy supervision.

May I repeat the earnest entreaty that you each seek to increase your understanding of this problem by utilization of the services of the information centers of your State Commission on Alcoholism; that you read as much as possible the stimulating and instructive literature that comes from A. A. publications and from books and pamphlets originating from the National Council on Alcoholism; that you familiarize yourselves with the letter and the spirit of A. A.'s suggested Steps and Traditions, and visit their open meetings to experience the deep and constant attraction of this fellowship. And finally, that you seek and encourage your own personal conversion to the conviction that the alcoholic is a sick man, a vital segment of suffering humanity whose potential worth in effective rehabilitation you may help re-activate and restore to useful service in our culture and our economy.

I salute your great state for the timely foresight manifest in this act. I salute the members of your Association who have worked so diligently and who have evolved so workable a plan. I congratulate you all on your unprecedented opportunity to share in its application and to prove that human frailty and sickness may be favorably influenced by considered and considerate action by a noble profession.

And now, may I congratulate the suffering alcoholic patients of this state whose thousands of voices have been heard, whose need has been more accurately recognized, and whose future holds more hope that they may be restored to self-respect, returned to the dignity of full and unqualified fellowship with mankind, and feel once again the enveloping warmth of the care and concern of God as they understand Him.

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Bi-Monthly Journal on Alcohol and Alcoholism

May-June, 1962 through March-April, 1963

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EDITORIAL

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connection with the public health problem of tuberculosis.

A person with active tuberculosis who refuses to abide by measures designed to protect others from his infectious disease may be sent, by due process of law, to the prison unit of the N. C. Sanatorium System for treatment as a health law violater. However, the act of contracting tuberculosis, per se, is not a crime, nor, of course, should it be any more than it should be a crime to have diabetes, pneumonia, alcoholism or ulcers, etc. The statute cannot be invoked merely because the patient refuses treatment, but only when he places other people's health and lives in jeopardy by his actions. Note, also, that the sentence is to a hospital where the best possible treatment for the condition is available—not to a jail.

In lieu of the ideal, and until the public is ready to face the truth and act accordingly, the least that should be done is to see that some effort is made to work with the public drunkenness offender as a sick person from the time he is taken into custody through incarceration. This is not too much to expect. It has been effective elsewhere. It can be effective in North Carolina. Dr. Thomas Jones, with poignant feeling and understanding, writes from experience in working with alcoholics and expresses his ideas on this subject in the article, *The Alcoholic—Patient or Offender?,* appearing in this issue. For other articles which shed light on aspects of this problem, and which have appeared in *Inventory* during the past year, read the entire July-August, 1962 issue and *Social Pathology, Urban Renewal and the Homeless Man,* January-February, 1963. (L.P.)

Short-Term Treatment for Alcoholics

If the premise that alcoholism responds only to long treatment remains unchallenged it can retard or limit efforts in behalf of alcoholics.

BY HERMAN E. KRIMMEL and D. BRUCE FALKEY

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ALCOHOLICS do not find a ready welcome in most agencies and clinics. There are probably several reasons for this, but prominent among them is the strongly entrenched notion that, without exception, alcoholics require long months or even years of treatment. If intake is open to many of these applicants, therefore, they will remain interminably, clutter up the case load, and exclude from service other clients and patients whose prognosis is more favorable.

Five years ago, when we began our work at the Cleveland Center on Alcoholism, we usually replied in routine fashion when asked about the length of treatment required for alcoholics. We solemnly advised alcoholics, members of their families, referring physicians, social workers, and others that alcoholism is an illness that takes a long time to develop and, consequently, a long time to treat successfully.

This, obviously, is a discouraging thesis. If every alcoholic requires long-term therapy, it is impossible in existing facilities to serve more than a small fraction of the estimated 4½-5 million alcoholics in the United States. This would be true even if those who seek help are accepted far more cordially than is current practice.

The outlook need not be so gloomy. Five years' experience with nearly two thousand patients has sharply altered our viewpoint and has given us reason for optimism. We know, of course, that many alcoholics do require treatment that may last from six months to a few years. However, we also know now that this is not true for all or even most alcoholics. (At the Cleveland Center on Alcoholism, men and women are eligible for treatment if their drinking is destructive, on a continuing basis, to their interpersonal relationships—family, friends, etc.—to their ability to earn a livelihood or hold a job, or if it impairs their health. We know that many who fit into these categories are not willing to label themselves as alcoholics. It is enough if they recognize that drinking is a problem to them.) A large percentage of our patients have been seen for only one to five interviews, and the rate of success—between 30 and 40 percent—has been about the same as for those treated over much longer periods! In this field no scientifically precise measure of success has been devised, but we have applied such conventional standards as sobriety and ability to function adequately in the family, on the job, and in the community.

If our experience can be applied elsewhere, it means that many more alcoholics can be treated within existing agencies and clinics. This does not mean the abandonment of long-range treatment. It means only that what works for one alcoholic may not work for another, for alcoholics are individuals with only one thing in common—they drink too much. It means that one alcoholic may need a hundred therapy hours but another might be helped with two or three counseling sessions. One client may require a battery of therapists including caseworker, psychologist, internist, and others. Another will get what he needs from a few hours with any one of these.

Professional workers in the field of alcoholism point with justifiable pride to their achievements in educating the public. Through their efforts the concept of alcoholism as an illness is gaining acceptance in ever widening circles, and it is now recognized as one of the three or four most serious public health problems in the nation. Old stereotypes are becoming obsolete. The prejudices about alcoholism as a "moral deviation" and the alcoholic as a "skid row derelict" still have supporters, but their number is steadily decreasing.

New Stereotype

New concepts, however, tend to create their own stereoptypes. The new concept that alcoholism is an illness has developed the stereotype that it is an illness responding only to long treatment. If this premise remains unchallenged it can retard or limit efforts in behalf of the alcoholic. Facilities for long-term treatment of large numbers simply do not exist and it is unlikely that many additional clinics will be available in the near future.

It should be noted, parenthetically, that the short-term approach does not ignore the nonclinical or nonagency approaches such as Alcoholics Anonymous. But even that highly successful organization reaches only a small 5-7 percent of the

alcoholic population, so that other community resources must be utilized to their fullest potential. Also, while it is true that the AA program works better than any other for many, it is equally true that there are alcoholics who will not or cannot use it.

The faith in the exclusive merits of long-term treatment has historical roots. It is partly the result of well-publicized opinion that alcoholism is primarily a psychiatric problem and that intensive psychotherapy is the only reliable instrument of treatment. This is traditionally accepted as a matter of months or years.

This attitude is slowly being modified, but it is so deeply rooted that many professionals find it difficult to let go. The suggestion that alcoholism is one illness in which it is frequently possible to treat the symptom without eliminating the cause is viewed as heresy. Dr. Harry M. Tiebout, a psychiatrist who was one of the first to advocate this symptomatic treatment, met vigorous opposition from his colleagues.

The experience has been similar in the field of social work. Caseworkers are dubious when it is suggested that the immediate goal in the treatment of the alcoholic patient is to get him to stop drinking and that all else is subordinate or must be deferred. If treatment eliminates the symptom (alcoholism) or abolishes a defense at the outset, they inquire, do you not risk more dangerous substitutes?

The answer is that for some clients this technique is eminently workable. It is a mistake to assume that clients have to replace one bad symptom with another. They may replace the unhealthy symptom with a healthy one. The alcoholic may replace drinking with intense vocational or avocational activity, and that is usually quite acceptable. The important thing is to find some satisfying activity to replace the drinking, but this does not always require prolonged therapy or "digging around" in unconscious conflicts.

Nor are caseworkers and psychiatrists alone in their doubts. In the five years that the Cleveland Center on Alcoholism has been in existence, every professional who has joined the staff—caseworkers, psychiatrists, internists, and psychologists — has asked the same questions. And each, as he or she has worked with alcoholics, has been persuaded that the most effective approach to treatment is to focus on the drinking and how it can be stopped as soon as possible.

Stop The Drinking First

Many factors may complicate the drinking and there may be interrelated problems, but these cannot be seen for what they really are by worker or patient until the drinking has stopped. Excessive drinking masks many problems, distorts others, and creates many that would not otherwise exist. For example, one of the most common reasons given by male alcoholics for their drinking is marriage to a nagging wife. Unquestionably, some wives are expert naggers. But an alcoholic may think his mate is nagging simply because she insists that the family income be applied to outstanding bills rather than to his drinking sprees.

Some men, when drunk, obscenely accuse their wives of the most flagrant infidelities, although when sober they know the accusations were false and may not even recall having made them. Or if it is not the wife who is blamed it may be the boss, whose demands, viewed through the alcoholic haze, seem totally unreasonable. It seldom occurs to the alcoholic that the demands seem unreasonable only because he is in the clutches of a relentless hangover.

He forgets that the job does not seem particularly difficult when he is not drinking.

For many of these patients it is sufficient that the therapy relationship effect only the cessation of the drinking. When this is done the surrounding problems may clear up almost simultaneously. More often they do not, but frequently the patient and his family can then work out solutions without additional professional help. The following two cases are illustrative.

Y's Case

Y drank like the proverbial fish every day. He managed to abtain during working hours but when he left the office he headed straight for a nearby tavern. Of course, he intended to have only "a shot or two for relaxation." From there he planned to walk home—about a mile away—because "it is good exercise and the fresh air revives a fellow with a sedentary job like mine." Unfortunately, much of the way was lined with taverns. As he walked, it seemed to him that there were powerful magnets in every doorway and complementary magnets in the toes of his shoes.

Something had to break the magnetic attraction. For Y it was antabuse, a medication which sensitizes a person to alcohol and makes him sick if he takes a drink. Properly used it can be an effective deterrent against that first drink. Consequently, each time he was attracted to a tavern entrance, the awareness of the antabuse in his system short circuited that attraction.

Drinking had created many difficulties in Y's marriage and in his work, but when he stopped drinking he was able to alleviate most of those problems. He had only three interviews at the center and in that time he achieved sobriety. The occasional medical follow-up advisable for a patient on antabuse was handled by his family physician. He has not had a drink for nearly three years.

Z was one of the best automobile mechanics in the city but he could not keep a job. If an employer dared to make a suggestion about his work on a morning when he was fighting a hangover (these mornings were numerous), he would abruptly walk off the job or become intolerably quarrelsome.

Besides the job difficulties there were street brawls and jail sentences. His wife finally divorced him when she could no longer endure the terrifying financial uncertainty, the cowering children, the violent sprees, and the harrowing episodes of contrition.

In his periods of sobriety Z was thoughtful, reflective, and capable of self-appraisal. During one enforced intermission in the county workhouse he decided that he had had it and wanted to stop drinking. He requested an appointment at the center immediately after his release.

A caseworker saw him four times and his ex-wife once. The interviews were spaced over a period of nearly two months. There was no magic formula and the process might not have worked for someone else. But it did for him. During that time he did not take a drink and, even more important, he convinced himself that he did not have to drink to live. Except for occassional telephone contacts there

was no additional communication with the center.

The dynamics of these interviews cannot be defined with any accuracy, but the important element was that the patient was accepted as a worthwhile human being instead of a hopeless drunk. Some realities of his situation were spelled out with him(not for him) and his genuine potential in his trade, if he could live without liquor, was discussed.

Undoubtedly, the temptation was strong for the psychiatrically oriented caseworker to intervene in other areas of a fragmented life. However, he resisted the temptation and waited for the call he was sure would come. It never did. The patient summoned up his own resources, which apparently were tough: He got a job, proved to himself he could "make it," and, when he was sure he had made it, remarried his former wife. After two and one-half years he is still working, still married, and still sober.

These are not miracles. Obviously more goes into rehabilitation than can be indicated in a few brief paragraphs and, perhaps, even more than is completely understood. The significant point is that these patients were given the help they needed at the time—help in the termination of drinking. They were able to take it from there.

The "cause" of alcoholism in these patients was not uncovered, but it was not necessary. Once rid of the symptom they were able to function capably in their society, which is all therapy can be expected to achieve at any level. This is not too different from a patient who has a temperature of 103 caused by an unknown virus. Medication reduces the temperature, the virus disappears, and the patient recovers his strength during the next few days without further medical help. Certainly, this does not mean that research into the nature and cause of the virus should be neglected any more than one should neglect the causes of alcoholism because prevention depends on that knowledge. But the fact that the cause is not understood does not render the treatment less effective.

Those who unyieldingly insist that brief therapy cannot be effective with alcoholics overlook the fact that the removal of the symptom can by itself produce dramatic changes. When an alcoholic parent in a family stops drinking, the environment is immediately altered, and in this changed atmosphere people interact differently. The new atmosphere does not always improve the situation, but it frequently can and does.

Reverse Process

Psychotherapists have stressed the vital importance of those buried emotional factors that motivate men to behave as they do in their social settings. Recognize and change these factors, they say, and men can better adjust to the environment. What no one seems to stress is that the process can be reversed. External change can modify internal dynamics. If, for example, tensions build progressively in a family because of increased drinking by the husband/father over a period of months, it does not seem too radical to suggest that these tensions will be eased if the drinking stops. The family members may then work toward recovery. It is quite possible that homeostasis functions in the emotional as well as in the organic area.

A person working with alcoholics may well be involved in short-term treatment for another inescapably practical reason—because the patient wants it that way. Many alcoholics do not see any need for continuing treatment when they have stopped drinking. They apply for help with

this specific problem and when it is solved they do not care to go further. This was the case with a 52-year-old patient who had a rather spectacular eighteen-year history of drinking. . .

A caseworker saw him in a single interview. That was more than four years ago and he has not had a drink since that morning. . .

This man said he did not need additional help. In this context he was given the support and impetus he needed at that particular time to battle the bottle. It was sufficient to know, he said, that the professional personnel of the center were available if he needed them. So far he has not.

That treatment does not necessarily begin with the first contact with a patient in that setting is something too often overlooked by agencies and clinics. Treatment, for some people, can be the accumulation of therapeutic experiences even though some of these seem to end in failure. For example, an alcoholic may see a physician, may go to a social agency, may even be active in Alcoholics Anonymous for a while. Nothing helps. Then he appears at the center and his drinking problem is quickly alleviated. It may well be that the other experiences were a necessary part of the preparation for the time when he became ready to accept and *use* help.

Of course, the sequence is not necessarily in that order. The center might well be the first in line with success coming in some other setting. In working with alcoholics, about whom so little is really known, episodes of trial and error in treatment are not wasted. That is especially true if these episodes had some consistency in the emphasis on the need to stop drinking as the primary goal.

The notion that short-term therapy somehow cheats the client is a mistaken one. It is no longer felt, for example, that surgical patients are cheated because they are encouraged, even compelled, to leave bed and hospital much sooner than was thought safe a decade ago. The cost is lowered, the patient is spared days and sometimes weeks of unnecessary confinement, and, with a faster turnover, hospitals can serve many more patients who need their facilities.

These same factors must be considered in all areas of service. Apart from other considerations, it is essential to explore the short-term treatment of alcoholics, when consistent with sound practice and the best interests of the clients, because of the economic demands. Few can afford long-term treatment. The specter of mounting expense will prevent them from seeking any sort of private, clinic, or agency help. The community must make every effort to reach the greatest number with the best possible service at the lowest cost.

Short-term treatment is not advocated for all alcoholics. It is most effective with those who have reasonably intact emotional and environmental resources that can be mobilized when the barrier of excessive drinking has been removed. Chronic alcoholics needing hospitalization or those with gross personality disorders can seldom be treated successfully without long, intensive therapy. The single, unattached alcoholic is also a poor short-term risk. Without the support of family or friends constantly around him, he may find it much more difficult to replace alcohol with other satisfactions. The agency usually must supply this support for a long time. Indeed, with this group the best efforts of a clinic or agency may not be enough because the interminable days between weekly appointments offer nothing but the bleak loneliness of a room without companion-

ship. This may be the reason why the fellowship of Alcoholics Anonymous seems to offer much more to these men and women.

Conversely, the prognosis for short-term therapy seems to be good for many patients who have maintained family ties. When they give up alcoholic beverages their recovery is frequently speeded by the relearning of the satisfactions of family living. The involvement of the family in the treatment of an alcoholic can be a vital asset.

Short-term therapy seems to be effective, also, with those patients who decide to seek help after a traumatic episode that frightens them. Sometimes it is destructive behavior during a blackout. One man came to the center after he had demolished the lower floor of his home in a drunken rage and realized, in the cold light of sobriety, what this performance had done to his wife and two small children. Another found a parking ticket from a distant city on his car one morning. He could not recall having driven to the city and the terror of what might have happened without his awareness made him seek help.

The alcoholics most amenable to short-term therapy are those who can, with help, face the reality of their situation fairly quickly. They can be confronted with the potential consequences of their continued alcoholic behavior and accept responsibility for it. They can realistically weigh the problems of sobriety against the possible disaster of drinking. They can be helped to recognize and use the strengths of their environment.

There is a decided need for short-term therapy. It works for many and, if its potential is fully employed, it offers the best hope of reaching more alcoholics at a much lower cost to the patients and the community.

GROUP THERAPY

CONTINUED FROM PAGE 11

further explanations concerning the development of alcoholism and, finally, what the treatment aims at. It is always emphasized that the goal of treatment is not sobriety alone but, also, to make the patient able to live a more constructive life and plan further ahead instead of merely satisfying immediate needs and desires.

There is not much discussion in the information group. The group leader just tries to make the patients realize that they are alcoholics in need of treatment. The information group is directed by one of the physicians, the psychologist or the social worker, but the group covered is always the same.

At the end of each week, all group leaders, some of whom are officers without academic training, meet together and discuss the various groups' progress during the week. The leader who has been instructor for the information group gives his impressions of the new patients. The new patients are then allocated to the already existing groups.

We try to "freshen up" groups which are very passive by putting in new patients who seem to be active; while new patients who give the impression of being very passive are put into more active groups. In this way we find we can preserve a sort of balance though, of course, we are sometimes misled by a patient's initial behavior and may have to reallocate him to a different group after a time.

At present, the groups meet three times a week for a session of one hour. Attendance is good. Most patients state that they benefit from the therapy although, in some cases, the long-term results can make one doubtful as to what the benefit is.

DIRECTORY OF OUTPATIENT FACILITIES

for

ALCOHOLICS AND / OR THEIR FAMILIES

Competent Help Is Available At The Local Level

Key to Facility and its Service

***Local Alcoholism Programs**

for
(Alcoholics and Their Families)

— Education
— Information
— Referral

†Mental Health Facilities

for
(Alcoholics and Their Families)

— Outpatient Treatment Services

‡Aftercare or Outpatient Clinics

for
(Alcoholics who have been patients of the N. C. Mental Hospital System)

— Outpatient Treatment Services

ASHEVILLE—

**Educational Division, Board of Alcohol Control;* Don Dancy, Educational Director; Parkway Office Building; Phone ALpine 3-7567.

†*Mental Health Center of Western North Carolina, Inc.;* 415 City Hall; Phone ALpine 4-2311.

BURLINGTON—

‡*Outpatient Clinic;* Alamance County Hospital; Hours: Wed., 9:00 a.m.-4:00 p.m.

BUTNER—

‡*Aftercare Clinic;* John Umstead Hospital; Hours: Mon.-Fri., 9:00 a.m.-4:00 p.m.

CHAPEL HILL—

†*Alcoholism Clinic of the Psychiatric Outpatient Service;* N. C. Memorial Hospital; Phone: 942-4131, Ext. 336.

**Orange County Council on Alcoholism;* Dr. D. D. Carroll, Director; 102 Laurel Hill Rd.

CHARLOTTE—

**Charlotte Council on Alcoholism;* Rev. Joseph Kellermann, Director; 1125 E. Morehead St.; Phone: FRanklin 5-5521.

‡*Mecklenburg Aftercare Clinic;* 1200 Blythe Blvd.; Hours: Mon.-Fri., 8:00 a.m.-5:00p.m.

†*Mental Health Center of Charlotte and Mecklenburg County, Inc.;* 1200 Blythe Blvd.; Phone: FRanklin 5-8861.

CONCORD

†*Cabarrus County Health Department;* Phone: STate 2-4121.

DURHAM—

‡*Aftercare Clinic;* Watts Hospital; Hours: Tues. and Fri., 2:00-5:00 p.m.

**Durham Council on Alcoholism;* Mrs. Olga Davis, Executive Director; 602 Snow Bldg.; Phone: 682-5227.

FAYETTEVILLE—

†*Cumberland County Guidance Center;* Cape Fear Valley Hospital; Phone: HUdson 4-8123.

GASTONIA—

†*Gaston County Health Department;* Phone: UNiversity 4-4331.

GOLDSBORO—

‡*Outpatient Clinic;* Cherry Hospital; Hours: Tues. and Fri., 10:00 a.m. - 12:00 noon. Thurs., 2:00-4:00 p.m.

**Wayne Council on Alcoholism;* A. T. Griffin, Jr., Executive Director; P. O. Box 1320; Phone: 734-0541.

GREENSBORO—

**Greensboro Counell on Alcoholism;* Worth Williams, Executive Director; 216 W. Market St., Room 206 Irvin Arcade; Phone: 275-6471.

†*Guilford County Mental Health Center;* 300 E. Northwood St.; Phone: BRoadway 3-9426.

‡*Outpatient Clinie;* 300 E. Northwood St.; Hours: Mon. and Thurs., 5:00-10:00 p.m.

GREENVILLE—

†*Pitt County Mental Health Clinie;* Pitt County Health Department, P. O. Box 584; Phone: PLaza 2-7151.

HENDERSON—

**Vance County Program on Aleoholism;* Dr. J. N. Needham, Director; 2035 Raleigh Rd.; Phone: GEneva 8-4702.

HIGH POINT—

†*Guilford County Mental Health Center;* 936 Montlieu Ave.; Phone: 888-9929.

JAMESTOWN—

**Aleohol Edueation Center;* Ben Garner, Director; P. O. Box 348; Phone: 883-2794.

LAURINBURG—

**Seotland County Citizens Committee on Alcoholism;* M. L. Walters, Executive Secretary; 308 State Bank Bldg.; Phone: 276-2209.

MORGANTON—

‡*Aftereare Clinie;* Broughton Hospital; Hours: Mon.-Fri., 2:00-4:00 p.m.

NEW BERN—

**Craven County Counell on Alcoholism;* Gray Wheeler, Executive Secretary; 409½ Broad St., P. O. Box 1466; Phone: 637-5719.

NEWTON—

**Edueational Division, Catawba County ABC Board;* Rev. R. P. Sieving, Director; 130 Pinehurst Lane; Phone: INgersoll 4-3400.

RALEIGH—

‡*Aftereare Clinie;* Dorothea Dix Hospital, S. Boylan Ave.; Mrs. Dorothy Ferrell, Psychiatric Social Worker; Phone: TEmple 2-7581, Ext. 421; Hours: Mon.-Fri., 1:00-4:00 p.m.

‡*Aftercare Clinie;* Rex Hospital; Hours: Mon., a.m. and p.m.; Wed., p.m.; Thurs. and Fri., a.m.

†*Mental Health Center of Raleigh and Wake County, Ine.;* 615 Wills Forest Rd.; Phone: TEmple 4-6484 or TEmple 4-6485.

REIDSVILLE—

**Roekingham County Committee on Aleoholism;* Mrs. Anne Wall, Executive Secretary; 225 W. Morehead St., P. O. Box 355; Phone: DIckens 9-4369.

SALISBURY—

**Edueational Division, Rowan County ABC Board;* Peter Cooper, Director; P. O. Box 114; Phone: 633-1641.

†*Rowan County Mental Health Clinic;* Community Bldg., Main and Council Sts.; Phone: MElrose 3-3616.

SANFORD—

†*Mental Health Clinie of Sanford and Lee County, Ine.;* 106 W. Main St., P. O. Box 2428; Phone 775-4129 or 755-4130.

SHELBY—

†*Cleveland County Mental Health Clinic;* 409 E. Marion St.; Phone: 482-3801.

SOUTHERN PINES—

**Moore County Alcoholic Edueation Committee;* Rev. Martin Caldwell, Director; P. O. Box 1098; Phone: OXford 2-3171.

WILMINGTON—

†*Mental Health Center of Wilmington and New Hanover County;* 1013 Rankin St.; Phone: ROger 2-8294.

**New Hanover County Counell on Aleoholism;* Mrs. Margaret Davis, Executive Secretary; 211 N. Second St.; Phone: 736-7732.

WILSON—

‡*Aftereare Clinie;* Encas Station; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Wilson County Mental Health Clinic;* Encas Rural Station; Phone: 237-2239.

WINSTON-SALEM

*†*Aleoholism Program of Forsyth County;* Marshall C. Abee, Executive Director; 802 O'Hanlon Bldg., 105 W. 4th St.; Phone: PArk 5-5359.

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